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Chief nurse executives' responses to impaired nurses

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CHIEF NURSE EXECUTIVES' RESPONSES TO IMPAIRED NURSES

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ABSTRACT

CHIEF NURSE EXECUTIVES' RESPONSES TO IMPAIRED NURSES

by Janice Read Klein

The purpose of this study was to describe the responses of Chief Nurse Executives (CNEs) to registered nurses (RNs) impaired by alcohol and other drugs. The study explored the personal and institutional factors associated with the CNEs' responses, and the relationship between the CNE's employment decision and the type of substance abused.

This descriptive study used a cross-sectional survey. The instrument, a 27 item questionnaire, was sent to 250 randomly selected CNEs, with a 67% response rate (N = 167).

The findings indicated a trend of less supportive CNE responses to drug impaired nurses, and more supportive CNE responses to alcohol impaired nurses. The majority of CNEs had encountered impaired practice.

Recommendations for further study include the CNE's willingness to employ recovering nurses, the CNE's motivation to maintain or terminate impaired nurses, gender differences in CNEs' responses, and the efficacy of King's model as a framework in responding to impaired practice.

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INTRODUCTION

Impaired nursing practice as a result of chemical dependency has been an issue that health professionals have been reluctant to address. Although impaired practice is not a new phenomenon, only recently has the nursing profession begun to grapple with how to acknowledge and treat the chemically impaired nurse. The profession has cared for its own by providing care and concern for the impaired nurse, while assuring the public that nurses are safe practitioners.

Since 1981, the American Nurses Association (ANA) and its state affiliates have formally endorsed the need to respond to chemically impaired nurses with an alternative to punitive sanctions and dismissals. The ANA passed a resolution at the 1982 convention calling for (a) the development of guidelines to be used by state nurses' associations to create care for impaired nurses; (b) the education of nurses, administrators, and employers regarding rights of impaired nurses; and (c) the ongoing collection and dissemination of information regarding issues of importance to the impaired nurse (ANA, 1982).

Statement of the Problem

The ANA estimated that between 120,000 to 160,000 (6% to 8%) of the nation's registered nurses have a problem with

alcohol or drug abuse. The National Council of State Boards of Nursing (NCSBN) reported that the majority of disciplinary actions taken between 1980 and 1986 were drug or alcohol related (cited in Elliott & Heins, 1988). Numerous studies pointed to the frequency with which impaired nurses (a) terminate, (b) resign, or (c) become part of a silent conspiracy in lieu of treatment (Hendrix, 1983; Isler, 1978; Jaffe, 1982). Rosen (1987) estimated that between 5% and 15% of the nation's practicing nurses are chemically dependent. Curtin (1987) stated that substance abuse among nurses and physicians is 50 to 100 times greater than abuse among the general public.

One of the first diversion programs for nurses in the United States was established in California. Assembly Bill 2674 (Agnos, 1984) authorized the Board of Registered Nursing (BRN) to establish a voluntary diversion program as an alternative to the traditional disciplinary process for chemically dependent or mentally ill nurses. The diversion bill was co-sponsored by the BRN and the California Nurses Association (CNA). A diversion program for impaired physicians had been established in California in 1980 (California Board of Registered Nursing, 1984b).

The purpose of the diversion program is to identify and seek means to rehabilitate registered nurses whose competency may be impaired due to mental illness or use of

drugs and/or alcohol. Services provided include (a) confidential consultation with a registered nurse, employer, family, or friends; (b) intervention services; (c) development of a rehabilitation plan; (d) monitoring participation and compliance; and (e) support.

Registered nurses licensed and residing in California who abuse drugs and/or alcohol in a manner that may affect the ability to perform the duties of a registered nurse may apply. Nurses who have sold drugs or paraphernalia, or have previously had their license disciplined by the BRN, are ineligible.

The BRN ensures the public's safety by regulating the practice of registered nurses. Regulatory responsibility includes responding to unprofessional conduct such as practicing while under the influence of a mind altering drug and/or the self-administration of nonprescribed, controlled drugs. Disciplinary actions in response to chemically impaired practice in California have historically involved probation, license suspension, and/or revocation. The BRN sought an alternative to the disciplinary response in part because it failed to address the problem in a timely manner. During the time interval between a complaint being filed and disciplinary action being taken, no work restrictions or treatment requirements were imposed. The disciplinary process made it possible for the chemically impaired nurse

to practice an average of 13 months prior to any disciplinary action being taken in the State of California (California Board of Registered Nursing, 1984b).

The BRN sought an alternative to disciplinary actions in part because it recognized chemical dependency and mental illness as treatable diseases. The diversion legislation provided a mechanism with which to ensure the impaired nurse's rights to rehabilitation in a confidential, therapeutic, nonpunitive environment. This provision was in accord with ANA's 1982 resolution. The diversion program takes immediate action to get the nurse into treatment as a therapeutic alternative to the disciplinary process (California Board of Registered Nursing, 1984b).

Assembly Bill 2674 created a program to closely monitor impairment due to chemical dependency or mental illness. For this purpose, the BRN established Diversion Evaluation Committees (DECs). Each committee has five members: (a) three registered nurses, (b) a physician, and (c) a public member. The five members have expertise in the field of chemical dependency and/or mental illness. The committees are responsible for (a) evaluating RNs who request entry to the program, (b) determining the RN's ability to continue or resume nursing practice, and (c) review and designation of facilities and services to

which RNs are referred for treatment (California Board of Registered Nursing, 1984b).

Participants must comply with DEC rehabilitation plans, which are individualized but usually include formal treatment programs, random urine testing, biweekly attendance at Alcoholics Anonymous (AA), and nurse support groups. The DECs also determine when a nurse has been rehabilitated, at which point all records of the nurse's participation are purged and destroyed. Failure to comply with the rehabilitation plan may result in expulsion from the program and reporting the nurse's name and license number to the board (California Board of Registered Nursing, 1984b). California has nine DECs, with two more in the planning stages.

Referrals are made in many ways. The BRN may refer eligible nurses from its disciplinary proceedings. The nurse may self-refer or be referred by employers, family, or friends. Requests for information or assistance are confidential. All information gained during the program is confidential and not available to the BRN or subject to discovery or subpoena. The BRN is notified only of unsuccessful completions.

Data obtained from state boards relate to disciplinary actions or voluntary contact only and thus cannot be assumed to represent the actual prevalence of impaired nurses in

California. The BRN estimated that anywhere from 4,400 to 22,000 of the 280,000 registered nurses in the State of California may be impaired. Since the California Diversion Program's inception in 1985, 813 licensed registered nurses have availed themselves of the program's service. Referral patterns indicate that 233 nurses self-referred, 543 were contacted by the BRN following a complaint, and 16 were employer referrals. A total of 156 nurses have successfully completed the program, and their records have been purged. Of the remaining nurses, 22 moved out of state, 4 died, 182 voluntarily withdrew, and 102 were dismissed for noncompliance (A. Schwab, personal communication, November 13, 1990). The objectives of both the disciplinary process and the diversion program are identical--to provide for public safety by ensuring that registered nurses are clinically competent to practice.

Purpose of the Study

The purpose of this study was to describe the responses of Chief Nurse Executives (CNEs) to registered nurses (RNs) impaired by chemical dependency. In addition, the study explored the personal and institutional factors associated with these responses.

For the purpose of this study, chemically dependent nurses were categorized in two major groups--alcohol impaired nurses and those nurses impaired by other mood and

mind altering drugs. Alcohol is also a mood and mind altering drug. These two major categories were selected because previous research indicated that CNEs may respond differently to nurses impaired by alcohol than to nurses impaired by other drugs (Hughes, 1989).

Research Questions

The goal of the study was to identify personal and institutional factors related to Chief Nurse Executives' responses to chemically impaired nurses. The following specific research questions were explored in this study:

1. What are the reported responses of CNEs to nurses whose professional functioning is impaired by the use of (a) alcohol and (b) drugs other than alcohol?

2. What is the relationship between the Chief Nurse Executive's employment decision and the type of substance abused by the nurse?

3. What personal and institutional factors are associated with the Chief Nurse Executive's responses to (a) alcohol dependent nurses and (b) drug dependent nurses?

Definition of Terms

Following are definitions of key terms as used in this study:

Chemical dependence is a state of psychological and/or physical addiction to a chemical substance (or substances) (Hughes, 1989).

Alcohol dependent nurse is a registered nurse whose personal and/or professional functioning is compromised by the excessive use of alcohol (Hughes, 1989).

Drug dependent nurse is a registered nurse whose personal and/or professional functioning is compromised by the excessive use of drugs other than alcohol (Hughes, 1989).

Impairment is a condition characterized by the inability to carry out professional duties and responsibilities in a reasonable manner consistent with nursing standards (Hughes, 1989).

Chemically impaired nurse is a registered nurse whose professional functioning is compromised by the excessive use of or dependence on one or more chemical substances (Hughes, 1989). The terms chemically impaired nurse and chemically dependent nurse were used interchangeably in this study.

Chief Nurse Executive (CNE) is a registered nurse who holds the top level administrative position in charge of nursing services in an inpatient health care institution (Hughes, 1989).

Pharmacologic optimism is a belief thought to be unique to health care workers that drugs are effective in relieving both physical and psychological pain (M. Lucero, personal communication, October 16, 1991).

Significance of the Study

The results of this study may provide data regarding chemically impaired nurses to key agencies involved in California nursing practice. Data reporting how California CNEs have integrated the diversion philosophy into their administrative practices have the potential to guide future educational efforts of both the BRN and CNA. The diversion philosophy seeks to identify and rehabilitate impaired nurses so they may return to safe practice, no longer endangering public health and safety.

This study has the potential to identify the need for, and encourage the promulgation of, sound written policies regarding chemically dependent nurses. These policies may affect the BRN, CNA, and California Association of Hospitals and Health Systems (CAHHS). Clearer, sounder policies would be extremely beneficial because the lack of policy adversely affects institutions, patient care, and the nursing profession.

This study reported whether or not impaired nurses were provided an alternative to punitive sanctions and/or dismissals. Reporting this crucial aspect of the diversion effort is key to assuring the impaired nurse an option for treatment as the profession cares for its own. This study provided a "snapshot in time" indicating how well the

diversion philosophy has been incorporated into the practice of the CNE.

Research Design

The study used a cross-sectional survey design to study responses of Chief Nurse Executives in acute care hospitals to impaired nurses. The variables included those diagrammed in Figure 1.

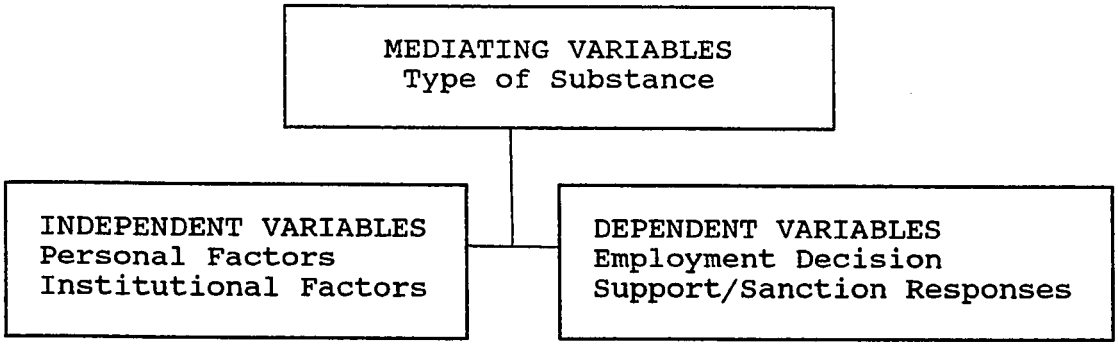

Figure 1. Conceptual diagram of independent, dependent, and mediating variables.

Note. From Chief nurse executives' responses to chemically dependent nurses by T. L. Hughes (1989). Doctoral thesis, University of Illinois at Chicago, Graduate College.

The study target population was comprised of CNEs employed as the top level executives for nursing in inpatient hospitals located throughout California. The inpatient hospitals were listed in the 1991 Membership Directory of the California Association of Hospitals and Health Systems (CAHHS). Federal agencies (armed forces,

Veterans Administration, and Indian hospitals) have unique reporting requirements regarding nurse impairment. Because these hospitals may employ nurses licensed in states other than California, all CNEs from federal hospitals were excluded.

Data were collected by questionnaire, using one mailing. The mailing included a cover letter describing the study, an agreement to participate (Appendix A), the questionnaire, and a self-addressed, stamped return envelope.

The instrument, a 27 item questionnaire (Appendix B), was developed for this study by adapting an instrument used in a similar study (Hughes, 1989). Hughes's questionnaire is in Appendix C.

Descriptive statistics including frequencies, ranges, percentages, and means were used to describe the sample and develop a profile of responses to items on the questionnaire. In addition, percentages were used to investigate possible relationships among responses to alcohol and drug dependent nurses by Chief Nurse Executives and other variables.

Limitations

Survey research has limitations in that (a) there is a tendency for respondents to give socially desirable answers, (b) the sample may not be representative of the target

population, (c) the information obtained in a survey tends to be superficial, and (d) large scale surveys can be time consuming and costly (LoBiondo-Wood & Haber, 1990). Further, the adapted instrument lacks established reliability and validity. Finally, the validity of this study was dependent on the honesty of the CNEs' responses.

Chapter 2

CONCEPTUAL FRAMEWORK AND REVIEW OF LITERATURE

The purpose of this chapter is to describe a conceptual framework that guided this research regarding responses to impaired practice. In addition, this chapter will provide a summary of existing factors associated with CNEs' responses to impaired practice.

Conceptual Framework

Imogene King's (1971) theory of goal attainment provided the conceptual framework for this study. The open systems framework is essential to understanding nursing as a major sub-system within the health care system. King (1971) stated that the focus of nursing is the care of human beings, with nursing's goal as the health of individuals and health care for groups. King described an interpersonal system formed by human beings interacting. From this interpersonal system, the concept of role as defined by King is relevant to this study. Specifically, the elements that give meaning to role are applicable in guiding the CNE's response to an impaired nurse.

King (1971) defined role as a set of behaviors expected when occupying a position in a social system. King's use of role concept also includes the principle that rules or procedures define rights and obligations in a position within an organization. The BRN, through licensure, has the

responsibility to uphold the ANA code of ethics, ensuring that nurses within the institution are competent to practice. Society has entrusted the nursing profession with monitoring nursing practice. One right accorded the CNE is the ability to establish written policies.

Hughes's (1989) study determined that the existence of a written policy and procedure regarding chemically impaired nurses was more influential in determining supportive responses than was the CNE's personal attitude. When the CNE maintains a professional role by establishing and following sound policies for response to impaired practice, there is goal attainment.

King (1971) also defined the third concept of role as a relationship with one or more individuals interacting in specific situations for a purpose. The CNE has multiple purposes in responding to the impaired nurse. The purposes include upholding the public's trust, assuring nursing is practiced by competent professionals, safeguarding the image of the institution in a highly competitive health care market, and intervening with the impaired nurse to facilitate rehabilitation and return to safe practice. Goal attainment is facilitated when the CNE maintains the rights and obligations accorded the position.

King defined organizations as being composed of human beings with prescribed roles and positions who use resources

to accomplish personal and organizational goals. The CNE is in a position to educate corporate level managers that providing treatment and rehabilitation for a chemically impaired nurse also supports corporate goals of retention of valued employees.

King's (1981) definition of authority describes one person influencing another in that the other recognizes, accepts, and complies with the legitimate and perceived power of the first individual. The CNE's authority is mediated by the employee assistance program (EAP) and perhaps a professional union regarding the impaired nurse's employment in the given institution. The CNE has authority to impose sanctions or support responses to impairment.

The major elements of this theory are seen in interpersonal systems in which two people come together in a health care organization to help and be helped to maintain a state of health that permits functioning in roles. If CNEs' responses were guided by this goal in responding to impaired nurses, rehabilitation would be offered universally in order to return the impaired nurse to the role of a safe practitioner.

King's (1981) theory of goal attainment has eight predictive propositions. King asserted, in the eighth proposition, that if nurses with special knowledge and skills communicate appropriate information to clients,

mutual goal setting and goal attainment will occur. This proposition is especially significant in the CNE's response to impaired nurses. When the CNE is able to communicate the reality of impaired practice as documented, observed behaviors, the appropriate information is helpful in cutting through the denial common to impaired nurses. King further stressed the need for mutual goal setting for goal attainment to occur.

King (1981) identified several assumptions about human beings and the nurse-client interaction. King asserted that individuals have a right to knowledge about themselves, whereas health professionals have a responsibility to share information to help individuals make informed decisions about their health care. If King's assumptions guided the CNE's responses, there would be no cases where information was withheld under the guise of helping the RN.

King's (1981) assumption that individuals have the right to accept or reject health care provides a theory based rationale for the CNE's response to the impaired nurse. King's theory thus acknowledges that despite the CNE's best efforts to facilitate the RNs' rehabilitation and return to safe practice, some impaired nurses reject health care and/or experience relapse following treatment.

A final assumption that King (1981) made about the nurse-client relationship is that the goals of health

professionals and the goals of the recipients of health care may be incongruent. The impaired nurse may not share the goal of a chemically free lifestyle.

The basic assumptions of King's theory of goal attainment, that nurses and clients communicate information, set mutual goals, and act to attain goals, are the basic assumptions of nursing process. King (1981) presented the following hypotheses derived from the theory of goal attainment:

1. Perceptual accuracy in nurse-patient interactions increases mutual goal setting.

2. Communication increases mutual goal setting between nurses and patients and leads to satisfaction.

3. Satisfaction in nurses and patients increases goal attainment.

4. Goal attainment decreases stress and anxiety in nursing situations.

5. Goal attainment increases patient learning and coping ability in nursing situations.

6. Role conflict experienced by patients, nurses, or both decreases transactions in nurse-patient interactions.

7. Congruence in role expectations and role performance increases transactions in nurse-patient interactions.

King (1981) asserted in hypothesis 4 that goal attainment decreases stress and anxiety in nursing situations. This hypothesis is particularly well suited in understanding the dynamics of decreasing stress and anxiety related to situations involving impaired practice. Hypothesis 4 is supported by O'Connor and Robinson's (1985) study that describes a decrease in stress when the impaired nurse is helped or reaches goal attainment. O'Connor and Robinson (1985) indicated there is relief (a decrease in stress and anxiety) at several levels: (a) the impaired nurse is relieved to be caught, (b) the peer group is relieved of enabling and protecting, (c) the manager is relieved of punitive options, and (d) the profession is relieved of denying the problem exists. Maladaptive responses include enabling and denial on the part of the nurse administrator.

In summary, King's theory of goal attainment provides a conceptual framework with the potential to guide the CNE's administrative practice so that it is likely the impaired nurse is provided a means of rehabilitation, the public safety is maintained, and the agency's reputation is not compromised by impaired nursing practice.

Literature Review

This review of literature includes research and other literature related to chemically dependent nurses, in order

to facilitate an understanding of employers' responses to the impaired nurses. The review is divided into the following sections: (a) chemical impairment among nurses, (b) responses to chemically impaired nurses, (c) personal factors (knowledge, nursing curricula, attitudes), (d) institutional factors (policies, employee assistance programs, employment of recovering nurses, the economic impact of impaired practice, insurance benefits), and (e) Chief Nurse Executives' roles and responsibilities.

Chemical Impairment Among Nurses

Poplar's (1969) study focused on female nurse addicts, excluding male nurse addicts. The 90 female subjects who sought treatment for drug addiction at the National Institute of Mental Health Clinical Research Center in Lexington, Kentucky, had three major concerns prior to their discharge: (a) ambivalence about revealing their addiction to potential employers; (b) fear of handling drugs, especially narcotics; and (c) the inadequacy of sources of support for sobriety.

As Deputy Director of Nurses at the agency, Poplar emphasized the psychological and social characteristics of nurse addicts. Psychological testing revealed distinct differences between female nurse addicts and other female addicts, in that nurse addiction began in adulthood rather than adolescence. The motivation was to escape pain,

emotional distress, or work pressure. Nurse addicts procured drugs through forged prescriptions or theft in the work place, not through prostitution, shoplifting, or the black market. As a group, nurse addicts were better educated than other female addicts. Testing revealed nurse addict profiles to be lacking in normal flexibility in interpersonal relationships to the degree that nurse addicts were described as ultra-conventional. Nurse addicts tested as having less than average sexual desires, preferring to view themselves as asexual. Whereas typical addict profiles measured low on impulse control, nurse addicts measured very high on impulse control. Poplar (1969) asserted that female nurse addicts are distinctly different from other female addicts, manifesting profiles that suggest female nurse addicts are more likely to recover than other female addicts.

Levine, Preston, and Lipscomb (1974) studied 12 nurses in the same facility. The purpose of the study was to identify antecedents to impairment. Analysis of the data indicated that (a) nurses had medical histories characterized by extensive and early use of hospitalization, and (b) dependence on alcohol preceded the nurses' dependence on other drugs. In Levine et al.'s study, nurses considered it an improvement to use drugs to self-medicate

their physical and/or emotional pain instead of using alcohol.

Bissell and Jones (1981) interviewed 100 white, abstinent female nurses who were members of Alcoholics Anonymous, to learn more about alcohol dependence among nurses. The nurse subjects were compared with a group of 97 male physicians. Nurses reported fewer sanctions, arrests, and informal admonitions not to drink than did physicians.

Bissell and Jones's 1981 study is not generalizable due to sampling techniques, yet it is widely quoted. The authors concluded that (a) nursing as a predominantly female profession was lagging behind its male dominated profession counterparts in recognizing and treating impairment within its ranks, (b) many impaired nurses were also highly competent professionals in the academic and administrative world, (c) there is a lack of information regarding nursing impairment, and (d) a conspiracy of silence within the nursing profession serves as an obstacle to support and assistance for the impaired nurse.

Sullivan's (1987) survey of 139 recovering nurses revealed histories notable for abuse, trauma, and dysfunction in the midst of academic and professional success. Unlike the Bissell and Jones study (1981), Sullivan's study found that addiction commonly progressed to the point at which these nurses had lost their jobs and

licenses. The majority of the subjects had been abstinent for 1 year. Relapse (at least one episode of drinking and/or drug use) was at a rate of 33%.

Responses to Chemically Impaired Nurses

The ANA Code for Nurses provides ethical standards for nursing practice that hold the nurse responsible to safeguard the client and public when health care is affected by incompetent, unethical, or illegal practice (ANA, 1976). Nursing practice is considered impaired when the individual is unable to meet the requirements of professional practice because cognitive, interpersonal, or psychomotor skills are affected (ANA, 1984). The ANA Ethical Code for Nurses links formal action to impaired practice evidenced in behavioral change and poor job performance (ANA, 1976).

Hughes's (1989) study was the first in the nation to assess the response of chief nurse executives to the chemically impaired nurse. Hughes (1989) categorized responses in two major categories as personal or institutional factors.

Personal Factors

Personal factors influencing the CNE's response include the individual's (a) knowledge, (b) attitudes, and (c) attribution of responsibility (Hughes, 1989).

Knowledge/nursing curricula. The nursing profession has promulgated the barriers to identification and

intervention by allowing curricula to focus solely on physiologic and toxic effects of mind altering substances to the exclusion of information concerning addiction as a process and factors relating to the development of impaired practice (Bissell & Haberman, 1984). Members of the helping professions are often as ignorant about alcoholism and drug abuse as nonprofessionals and seldom intervene until the problem can no longer be ignored. The intervention gestures are woefully inadequate and at times compound the problem (Green, 1984; Isler, 1978; Valentine, 1988).

Burkhalter (1975) stressed the need for curricula content evaluation and revision to include the addictive process and a clinical component in the psychiatric affiliation. Hoffman and Heinemann's (1987) survey of 336 nursing programs indicated a common practice of allocating 1 to 5 instructional hours for drug and alcohol content in diploma, associate degree, and baccalaureate programs. Given the scope of this national health problem and the likelihood of impaired professionals in practice, the allocation of instructional hours was found to be disproportionate to the problem (Hoffman & Heinemann, 1987).

Finley (1982) asserted that existing curricula primarily deal with issues related to male substance abuse. Most research has focused on male subjects, because females pose problems as research subjects due to changing hormonal

levels that complicate data collection and analysis (Schuckit, 1984). Until recently, it was erroneously assumed there were minimal differences between male and female addicts (Bennett, Vourakis, & Woolf, 1983). As sex related differences became apparent, so did the need for curricula reflecting issues related to female addiction.

Schlesinger and Barg (1983) surveyed 1,436 programs approved by the National League of Nursing, with a response rate of 68.3%. Respondents indicated 4% of the curricula and 10% of the faculty research focused on substance abuse. The study proposed one reason for the low percentage in both areas may be that nurse educators lacked sufficient background to train the next generation of nurses or conduct research in this specialty.

Progress has been made in developing special curricula with programs having chemical dependency as a focus for a nursing specialty (Chappel, Veach, & Krug, 1985; Hoffman & Heinemann, 1987). The University of Washington's School of Nursing is aimed at both generalist and specialist skill levels in working with alcoholism. The 1983-84 California Legislature revised the Nursing Practice Act to require that all RN students who matriculate on or after September 1, 1985, have training in the detection and treatment of alcohol and substance dependency (Nursing Practice Act, 1984).

Guidelines have been developed to provide schools of nursing with standards for inclusion of chemical dependency in the curriculum in a course or by integration throughout the curriculum. The objectives specify that upon completion of the required course(s), the student nurse will (a) know various theories; (b) discuss aspects of etiology; (c) understand the epidemiology throughout the growth and development cycle; (d) apply nursing process in providing care; (e) know primary, secondary, and tertiary intervention modes; and (f) discuss issues related to reentry of chemically dependent persons (Nursing Practice Act, 1984).

The course content includes information regarding the general population and subgroups such as females, gay men and lesbians, and health professionals. A section is required that has a focus on the chemically dependent nurse and licensure that includes (a) incidence, (b) patterns of drug and alcohol abuse, and (c) the Nursing Practice Act's provisions for disciplinary proceedings and information regarding the Diversion Program. Clinical experience planned with attention to the chemically dependent client is desirable but not required by the BRN (Nursing Practice Act, 1984).

The BRN has also issued guidelines (1984) for schools of nursing in dealing with impaired nursing students, which recognize (a) the disease concept, (b) that recovery is

possible, (c) that the nursing student is responsible to voluntarily seek diagnosis and treatment, and (d) that confidential handling of the diagnosis and treatment is essential (Board of Registered Nursing, 1984).

The BRN expects schools to provide appropriate assistance directly or by referral. Instructors are to be empowered by the authority to take corrective action immediately regarding conduct and performance in the clinical setting. The BRN requests that schools provide factual material to incoming students regarding school policy (Board of Registered Nursing, 1984).

Attitudes. Numerous studies verify the general public's stereotypical perceptions of the alcoholic. Mulford and Miller's (1964) study of 1,213 adult Iowans revealed that only 24% accepted the disease concept without qualification, 34% defined the alcoholic in purely moralistic terms, and 60% considered the alcoholic weak willed. Dean and Poremba (1983) reported that although many professionals considered the client's acceptance of the self-label "alcoholic" as a prerequisite to recovery, the label remained a highly stigmatized term, which the general public equated with a skid row habitué. Though this study is not generalizable beyond Iowa, it does point out the possible deleterious effects of public opinion.

Mendelson and Mellow (1979) reported that the World Health Organization recommended the term alcoholic be abandoned and replaced with the term "alcohol dependence," fearing the term alcoholic could not be redefined in the public's eye. Orcutt, Cairl, and Miller (1980) explored ideological conceptions of alcoholism held by four groups: (a) law enforcement officers, (b) detoxification center staff, (c) college students, and (d) the general public. The detoxification center staff subscribed to the medical model. Law enforcement officers were less likely to subscribe to the medical model. Almost three fourths of the law enforcement officers subscribed to the moral sickness category. College students were neither as moralistic as law officers, nor as medically oriented as health care staff. The study indicated the public's inability to accept and endorse the disease concept in its understanding of deviant drinking.

Studies to date have indicated alcoholics are viewed less negatively than individuals addicted to other drugs. Sowa and Cutter (1974) reported hospital staff held less positive attitudes toward drug addicts and more positive attitudes toward alcoholics. Knox (1983) found similar attitudes evidenced in administrators' application of preemployment requirements, in that alcoholics experienced less stringent regulations than did other addicts in the

fields of engineering, fiscal services, and personnel services.

Many studies were conducted in the late 1960s and 1970s to investigate the attitudes of nurses and student nurses toward alcoholics. Ferneau and Morton (1968) revealed conflicting caregiver beliefs such as: (a) alcoholism was an illness, but (b) alcoholics could control their drinking behavior and were weak-willed individuals. Reliability checks by Ferneau and Morton (1969) indicated the attitudes remained constant. Harlow and Goby (1980) replicated Ferneau and Morton's (1968) study and found that knowledge and attitudes improved and remained constant when students were provided clinical instruction and clinical placement in an alcoholic treatment program.

Naegle (1983) indicated that ambivalence, the coexistence of positive and negative feelings toward the same person, causes the nurse to be drawn in opposing directions regarding an impaired nurse. The nurse's ambivalence may have a source in the internalized professional image. The nurse may have a strong stigma about alcoholism yet recognize the attitude as incompatible with a caretaking role. The alcoholic's childlike dependence may evoke traditional stereotypical nursing roles, which at the same time are nontherapeutic. The nurse may experience strong negative feelings when the alcoholic

patient is obstreperous, irresponsible, and a source of pain, abuse, or death to another. The client's denial and resistance may create a premature sense of defeat for the nurse who aspires to return the client to an improved state of health.

Cannon's (1987) study of 396 Oregon nurses found nurses with fewer years of employment and advanced education had significantly more positive attitudes toward impaired nurses than did their counterparts. Further, impairment by alcohol was viewed more positively than was impairment by other drugs.

Dean and Rud (1984) studied 256 respondents from a small, upper middle class western college town assessing first impressions of the term "drug addict." The overwhelming perception was an image of a disoriented, unhealthy, thin, lower class, male "hippie." The same population had been used in a previous study (Dean & Poremba, 1983) measuring images associated with the word "alcoholic." The negative stereotype in 1984 was similar to the response to alcoholics reported in the 1983 study. The authors suggested the term drug addict should be abandoned because of negative stereotypes. The study was limited geographically.

The stereotype of the drug addicted nurse is that of a slovenly, unkempt nurse, reminiscent of Sairey Gamp,

Dickens's fictitious nursing figure. The reality is that chemically impaired nurses are likely to be outstanding, achievement oriented nurses (Green, 1984). The more accurate stereotype of the addicted nurse that is diverting drugs from the patient involves specific behaviors such as (a) volunteering to give medications, (b) frequently wasting drugs, (c) pouring maximum doses of analgesics, and (d) frequent complaints from patients that analgesics administered by the impaired nurse were ineffective in diminishing pain (Sullivan, 1986).

Hendrix, Sabritt, McDaniel, and Field (1987) explored perceptions and attitudes toward nursing impairment held by 1,047 registered nurses, using a 32 item Likert-like survey questionnaire. Supervisors were most likely to perceive the need for disciplinary action, whereas staff nurses were more likely to view impairment as treatable. There were significant differences found between attitudes toward alcohol and drug abuse and emotional distress. Impairment was more likely to be seen as an illness when it involved emotional distress, not alcohol abuse. There were more disciplinary measures when impairment involved drug or alcohol abuse than when it involved emotional distress.

Hughes's (1989) landmark study was the first in the nation to explore exclusively the CNEs' responses to alcohol and drug impaired nurses. This mail survey of 195 Illinois

CNEs indicated impaired practice was a problem to most CNEs. Hughes reported that CNEs' responses were influenced more by institutional factors such as policies and employee assistance programs, and less by personal factors such as attitudes and information.

Institutional Factors

Policies. Institutional factors influencing CNEs' responses to impaired nurses include (a) policies, (b) employee assistance programs, (c) reemployment, (d) insurance, and (e) the CNE's role (Hughes, 1989). The importance of policies to guide responses to chemically dependent nurses has been stressed by authorities (Abbott, 1987; ANA, 1984). However, many hospitals lack written policies to guide the nurse administrator's response to impaired practice (Miller & Pietsch, 1988; Valentine, 1988). The results of a pilot study in Missouri revealed only 39% of the hospitals had written policies (Hughes, 1988).

Lack of administrative support and absence of adequate institutional policies can impede intervention. The lack of institutional policy is best remedied by educational programs, development of sound policies and procedures, intervention training, and familiarity with referral sources. Correction of policy deficits creates a climate and structure for attitudinal and behavioral change toward the impaired nurse (Gelfand, Long, McGill, & Sheerin, 1990).

Model policies have provisions for reentry to practice that require total abstinence. Although abstinence is the only goal, sound policies must also recognize the likelihood that some nurses will relapse. An enlightened policy makes provisions for relapse that include support, consequences, and adherence to the ANA Code regarding nursing practice (Hughes, 1989).

Employee assistance programs. An employee assistance program (EAP) is a management tool that provides services to employees when job performance is threatened or adversely affected by personal problems including stress, emotional illness, and dependence on alcohol or drugs or both. EAPs motivate employees to seek and accept help. The employee may self-present or be referred by a supervisor for confidential assessment, intervention, and referral for appropriate services. EAPs are especially concerned when problems affect job performance. The American Hospital Association (AHA) has published guidelines to establish EAPs (Blair, 1985).

The health care industry has lagged behind others in the use of EAPs. Even though the incidence of occupational stress per 100 full-time employees is 58% higher for health care employees than for other industry employees (Calhoun, 1980), the health care industry has not used EAPs as frequently as their counterparts in industry.

Early in the 1980s, the California Board of Registered Nursing adopted a position statement supportive of EAPs for impaired nurses, which reflected a belief that alcohol and drug dependence are treatable diseases from which an impaired nurse can recover (California Board of Registered Nursing, 1984a). Responsibility for seeking treatment remained that of the impaired nurse, whereas confronting the impaired nurse who endangers patients remained a responsibility of each nurse in practice. Despite such encouragement to provide EAPs, hospitals have been remiss in providing these programs. Fewer than 50% of the hospitals surveyed nationally have EAPs (Substance abuse, 1987). Because health care professionals under-utilize EAPs, peer assistance efforts have been undertaken by volunteers.

Peer assistance programs provide information, referral, intervention, peer support groups, education, and consultation. Volunteers are nurses with personal or educational backgrounds in addictions in nursing (Pace, 1990).

EAPs have similar goals and may in addition require credentialing of counselors who are not generally RNs. EAPs are equipped to provide expert consultation to supervisors and union stewards (Pace, 1990).

Insurance benefits. Insurance coverage for the treatment of chemical dependency reflects the employer's

basic commitment to rehabilitation and reemployment (Hughes, 1989). Because of rising health care costs, many employers are limiting coverage to detoxification or outpatient rehabilitation programs, instead of the traditional 28 day inpatient programs. This trend has resulted in state legislatures mandating that insurers offer substance abuse coverage in their policies (Substance abuse, 1987).

Employment of recovering nurses. In general, potential employers have manifested avoidance behaviors toward alcoholics and drug abusers, applying more stringent preemployment requirements to drug abusers (Knox, 1983). Hughes's (1989) study indicated more CNEs have supportive management responses to alcohol impaired nurses than to nurses impaired by drugs other than alcohol.

Several studies (Sullivan, 1987; Valentine, 1988; Yeary, 1987) suggested that impaired nurses are a good treatment risk. Of 130 residents in the Nightingale Program (Valentine, 1988) for impaired nurses, less than 10% have relapsed and over 50% have returned to work for former employers. Reportedly, the Nightingale Program residents are serious about their desire to return to nursing practice and willing to deal with complexities imposed by the board to reinstate their licensure.

Sullivan's (1987) mail survey of a national sample of 139 recovering chemically dependent nurses showed relapse

was infrequent. The incidence of relapse (at least one episode of drinking and/or drug use) was 33% (n = 47). Ninety of 139 nurses from 24 states remained abstinent from all mood altering chemicals since they began recovery. However, the results of this study cannot be generalized due to the sampling procedure and the survey design of the study. Chemically dependent nurses who are not in recovery may differ from those who engage in recovery. Recovering nurses may be more motivated personally and/or professionally to seek and accept help. In a California study of 35 recovering nurses, 60% were able to return to hospital practice without relapse (Yeary, 1987).

Because nurses make decisions about returning to work in the extended phase of recovery, it is useful for the nurse administrator to have a working knowledge of Horberg and Schnoll's (1983) phases of recovery. According to Horberg and Schnoll (1983), during the premotivation phase, nurses are in denial, hoping to return to "using" occasionally, and abstinent primarily due to external pressure. In the breakthrough phase, the nurse admits a problem, wants change, and usually is buoyant in mood and lacking in maturity. Early recovery is a time of new identity as a drug-free person. Extended recovery is a time of acknowledging feelings too painful to deal with in prior recovery. It is in this stage that nurses decide if they

want to return to the profession and provide direct patient care. Nurse administrators need interviewing skills to determine the nurses' progress in recovery as they evaluate readiness to reenter the work force and plan appropriate reentry (Abbott, 1987; Veach, 1987).

California has mandated written return-to-work contracts for all diversion program participants, which monitor the nurse's progress and encourage the nurse to focus on recovery. Such agreements limit assignments and require participation in 12 step programs and drug and alcohol screens on a regular basis (Clemmer, 1987).

Economic Impact of Impaired Practice

A cost analysis to determine the specific economic impact of impaired nursing practice (LaGodna & Hendrix, 1989) revealed a combined cost estimate of $54,120 per impaired nurse in Kentucky. About 59% of the cost is born by the impaired nurse ($31,953), 33% by the employing agency ($17,867), and 8% by the professional regulatory agency ($4,300). These figures are even more impressive when seen in the context of rising health care costs and a nursing shortage during which recruitment and retention strategies have been intensified.

From a practical standpoint, the profession cannot afford to "throw away" between 10% and 20% of the existing nurses. The profession is facing a shortage of up to a

quarter of a million nurses by 1992 (Curtin, 1987), although recent economic changes may affect this prediction. Research demonstrates conclusively that treatment of impaired professionals succeeds in 90% of the cases (Curtin, 1987).

Chief Nurse Executives

Roles/Responsibilities

Naegle (1985) emphasized the need for creative management of impaired nursing practice as nurse administrators face the dilemmas of responsibility to quality patient care and the responsibility as an advocate for the nurse employee. Although all nurses have a responsibility in responding to the chemically impaired nurse, only the CNE is empowered with the authority to advise the nurse that failure to seek treatment will result in automatic notification of the BRN. Any individual in the state may report anonymously.

Hutchinson (1987) pointed to the need for a proactive role of the CNE in creating policies and procedures to respond to chemically dependent nurses, indicating the CNE's need to grasp the self-annihilation trajectory of becoming chemically dependent, in order to make effective managerial decisions concerning the impaired nurse. The goal is to intervene at the earliest point on the trajectory. Abbott (1987) also stressed the need for policy planning, asserting

that 85% of the impaired nurses respond positively to an established, comprehensive policy.

The Certo-Guinan and Waite (1991) study identifying the role of Directors of Nursing in the State of Florida indicated that absence of policies and protocols providing frameworks for intervention in most facilities represented in the study suggested little was being done at the management level. This study had limitations in that the number of mailed questionnaires and the number of respondents were not reported, nor was there an abstract summarizing the study. The main thrust of this study indicated the author's belief that CNEs have a responsibility to assure policies are in place which facilitate treatment. The three most frequent approaches to managing drug diversion include (a) an administrative approach in which the impaired nurse is dismissed or allowed to resign, (b) a referral to enforcement agencies, and (c) a cooperative approach among law enforcement, inhouse security, policy, and the nurse administrator to identify the impaired nurse and refer to appropriate treatment (Ferrara, 1985).

Hughes's (1989) study utilized the four models of Brickman et al. (1982) regarding the response to impaired practice as a framework for evaluating helping behaviors of CNEs to impaired nurses. Brickman et al. focused on

attribution of responsibility for the cause of the problem (impairment) and the solution (sobriety). Of these models, 98% of the CNEs agreed with the compensatory model, which sees the impaired nurse as needing to work with others to attain sobriety. Only 32% of the CNEs agreed with the medical model, which states the impaired nurse must rely on trained experts to overcome dependency. The moral model statement was selected by 40% of the CNEs, who held the impaired nurse responsible for overcoming dependency on his or her own. The enlightenment model, which indicates impaired nurses must accept authority and discipline of others in overcoming their dependency, was chosen by 12% of the CNEs (Brickman et al., 1982).

Summary

Although progress has been made in acknowledging chemical dependency in nursing, additional nursing research is necessary to understand the multitude of factors that influence the CNE's response to the impaired nurse. This study provides a baseline indicating the California CNEs' responses to impaired nursing practice.

Chapter 3

METHODOLOGY

Research Design

This descriptive study used a cross-sectional survey design to study responses of Chief Nurse Executives in acute care hospitals to impaired nurses. The research questions were:

1. What are the reported responses of CNEs to nurses whose professional functioning is impaired by the use of (a) alcohol and (b) drugs other than alcohol?

2. What is the relationship between the Chief Nurse Executive's employment decision and the type of substance abused by the nurse?

3. What personal and institutional factors are associated with the Chief Nurse Executive's responses to (a) alcohol dependent nurses and (b) drug dependent nurses?

Subjects and Setting

The target population was Chief Nurse Executives, the highest level nursing administrator, in acute care hospitals in California. The 250 subjects were selected randomly. Consecutive tables of random numbers were obtained from a statistical text (Freund & Smith, 1986). The precise point of entry to the tables was determined by a process involving several steps. The first two digits from a five dollar bill identified the entry point into the table of random numbers.

The first digit indicated how many rows to move downward from the first column in the top left corner. The second digit indicated how many rows to move horizontally. A five cent piece was tossed. The resulting heads up indicated the table of random numbers would be used vertically across the page. Each set of numbers contained five digits. The first three digits were used as random numbers to obtain a sample.

The alphabetized membership list of the California Association of Hospitals and Health Systems provided names and addresses of 476 acute care agencies in California. All federal facilities such as armed forces, Veterans Administration, and Indian hospitals were removed from the list. The specific names of the CNEs were obtained from the American Hospital Association Directory of Health Care Professionals (1991), when listed in the directory.

Human Subjects Approval

Human subjects approval was granted June 24, 1991, by the Institutional Review Board at San Jose State University. A sample cover letter, agreement to participate, questionnaire, return and outer envelope, and a followup letter were submitted, along with an abstract and required forms.

Data Collection

Data were collected by mailed questionnaire. The first mailing to 250 CNEs included a cover letter, participation

agreement, questionnaire, stamped return envelope, and a two dollar bill as an incentive, as approved by Human Subjects. Of the 177 questionnaires returned, 167 were usable. Six questionnaires were not usable, having been completed by professionals not functioning as a CNE. The response rate was 67% (N = 167).

Return envelopes were identified by a code number used to track response rates. Questionnaires were separated from their envelopes upon receipt to assure they remained completely anonymous. After the envelope and questionnaire were separated, a code number was assigned to each questionnaire. Responses were coded for entry into a computer by statistical analysis. Each response to the questionnaire was assigned a numerical value, which was coded on the Cobol sheet. The questionnaires, envelopes, and Cobol sheets were kept in a locked file and destroyed following analysis.

Instruments

Data were collected by mailed questionnaire, which was adapted from a questionnaire by Hughes (1989). This study's questionnaire was designed according to feedback regarding Hughes' (1989) survey. This study's questionnaire was pilot tested by two CNEs who were not a part of the study.

The 27 item questionnaire elicited demographic information as well as personal and institutional factors

associated with the CNE's response to impaired nurses. Some questions utilized a Likert-type response, and others utilized a Yes/No/NA format.

Analysis

Descriptive statistics including frequencies, ranges, percentages, and means were used to describe the sample and develop a profile of responses to each item on the questionnaire. Also, frequencies and percentages were used to investigate possible relationships among study variables.

Scope and Limitations

The study was limited by sample, design, and instrument. The sample referred to CNEs in California. Findings are generalizable only to the target population (Burns & Grove, 1987). In addition, respondents may differ from nonrespondents. Cross-sectional survey design collects data at one point in time. No assumptions can be made about cause and effect using this design (Burns & Grove, 1987).

The instrument, a questionnaire, does not provide a means to clarify questions (Burns & Grove, 1987). Questionnaires with objective items may miss the subtle responses obtained during an interview. Because of the limitations, the findings of this study are generalizable beyond the sample only with caution.

This study was a study of 167 CNEs who responded to a questionnaire. There was no provision on the questionnaire

for write-in responses or other ways the CNEs could embellish their responses. Survey research misses the subtlety and detail of other research methods such as interviews. The study included only nine male CNEs, which, even though reflective of the percentage of CNEs who are male, was too small a number on which to base firm conclusions about gender differences.

The sample size was sufficiently large, but the number of CNEs responding to some items was too small to allow valid statistical comparisons to be made. The chi-square statistic could not be used to analyze differences due to small cell frequencies.

A number of problems were discovered with the questionnaire after it had been sent. For example, Question 23 asked if the curricula from the highest degree program prepared the CNE to respond to impaired nurses. Because of this item's positioning under an item asking for their highest nursing degree, there may have been confusion about on which "highest degree program" they were to base their response.

A problem arose in the design of the analysis, which was intended to compare alcohol impaired and drug impaired nurses. To answer the question of differences between these two groups, Item 11 (with its 12 factors) was cross-tabulated with Items 5 and 10 or 4 and 9. The fact that

Item 11 referred specifically to the CNE's decision to terminate an impaired nurse conflicted with the CNEs' management decision as reflected in Items 5 and 10 (to allow the nurse to resign, to return the nurse to work, to refer the nurse to treatment, or to report the nurse to the BRN) and the CNEs' employment decision as reflected in Items 4 and 9 (to maintain, terminate after trial, or terminate the nurse immediately). This complex design, compounded by the lack of statistical tests because so few CNEs indicated that they allowed impaired nurses to resign, greatly diminished the clarity of interpretation for analyses involving Item 11.

Chapter 4

FINDINGS AND INTERPRETATION

Introduction

This chapter presents findings from this study examining Chief Nurse Executives' responses to impaired nurses. Responses from the survey were analyzed with frequencies and percentages to answer the research questions. This chapter is divided into three sections. The following section presents information about the demographic characteristics of the sample. The second section presents results relative to the research questions. The final section presents a summary of the findings from the survey.

Description of the Sample

Of the 250 Chief Nurse Executives sent surveys, 167 (67%) returned surveys. The demographic characteristics of these nurses are presented in Table 1. The mean age of the respondents was 46.30 years (SD = 6.59). The ages extended from 32 at the youngest to 63 at the oldest. The expected majority (95%) were female. The sample was well-educated, with 59% holding a master's degree and 29% holding a bachelor's degree.

The hospitals at which the responding nurses were employed had a mean size of 191 beds. The sample was limited in that no federal hospitals, which are generally

Table 1

Demographics of the Nurses in the Sample (N = 167)

Characteristic	n	%
Age		
M = 46.30		
SD = 6.59		
Range = 32-63 yrs		
Gender		
Male	9	5%
Female	158	95%
Education		
Diploma	6	3%
AA	13	8%
BA	49	29%
MA	98	59%
Missing	1	1%
Total	167	100%
Number of Beds in Hospital		
M = 191.61		
SD = 191.43		
Number of RNs in Hospital		
M = 262.80		
SD = 295.25		
Type of Hospital		
Public	27	16%
Private	85	51%
Teaching	4	2%
Other	27	16%
Public/Teaching	6	3%
Public/Other	1	1%
Private/Teaching	6	4%
Private/Other	9	5%
Teaching/Other	1	1%
Private/Teach/Other	1	1%
Total	167	100%

large, were included, thus limiting the size of the hospitals. Likewise, the mean number of RNs at the hospitals where the responding nurses were employed was 262.80, with a standard deviation of 295.25.

CNEs were also asked to respond to two questions regarding preparation for dealing with impaired nurses. The first question asked, "Did the curricula from your highest degree prepare you to respond to impaired nurses?" As seen in Table 2, of the 167 respondents, the majority (89%) of the CNEs said they were not prepared to deal with impaired nurses. Nurses were also asked to indicate "their primary sources of information regarding impaired nurses." The most common answers were the Board of Registered Nursing (22%) and past experience (26%).

The personal factor of knowledge was assessed by Item 24, which asked the respondent to identify his or her primary source of information regarding impaired nurses (see Table 2). Past experience was the most frequent response (26%), with the BRN listed as the second most frequent response (36%). The least frequently used source of knowledge was AA/NA meetings.

The personal factor of nursing curricula was assessed in Item 23, which asked, "Did the curricula from your highest degree prepare you to respond to impaired nurses?"

Table 2

Preparation of CNEs for Responding to Impaired Nurses

Question	n	%
Did the Curricula from Your Highest Degree Prepare You to Respond to Impaired Nurses?		
Yes	17	10%
No	149	89%
Missing	1	1%
Total	167	100%
Primary Source of Information Regarding Impaired Nurses		
Courses	10	6%
Continuing Education	22	13%
Inservice	6	4%
Professional Journals	11	7%
AA/NA Meetings	1	0%
Board of Registered Nurses	36	22%
Past Experience	44	26%
Other	14	8%
Missing	23	14%
Total	167	100%

(see Table 2). Only 10% of the respondents indicated that the curricula from their highest degree had prepared them to respond. The low percentage may be related to the wording

of the question, which referred only to the highest degree obtained, thus excluding other curricula.

Results

Research Question 1

The first research question was as follows: What are the reported responses of CNEs to nurses whose professional functioning is impaired by use of (a) alcohol and (b) drugs other than alcohol? To answer this question, responses to Items 1, 2, 6, and 7 of the survey were tabulated. Results are presented in Table 3.

Item 1 asked, "In the past 5 years, have you made any disciplinary decisions about registered nurses whose professional functioning was impaired by alcohol dependency?" Item 6 asked, "In the past 5 years, have you made any disciplinary decisions about registered nurses whose professional functioning was impaired by drug dependency?" CNEs answering the survey had made disciplinary decisions regarding both alcohol impaired nurses (65%) and drug impaired nurses (74%). Item 2 was, "Have you employed any nurses who are recovering from alcohol dependency?" Item 7 was, "Have you employed any nurses who are recovering from drug dependency?" Slightly more CNEs employed alcohol impaired nurses (64%) than employed drug impaired nurses (61%).

Table 3

Number and Percentages of CNEs Making Disciplinary Decisions and Employing Impaired Nurses

	Involving Alcohol		Involving Drugs	
	n	%	n	%
In the past 5 years, have you made any disciplinary decision about impaired nurses?				
Yes	109	65%	124	74%
No	56	34%	43	26%
Missing	2	1%	0	0%
Total	167	100%	167	100%
Have you employed any nurses who are recovering?				
Yes	107	64%	101	61%
No	56	34%	62	37%
Missing	4	2%	4	2%
Total	167	100%	167	100%

CNEs also answered a question relating to the response made regarding whether to allow the impaired nurse to resign, return the nurse to work, refer the nurse to treatment (this included referring the nurse to the California Diversion Program, referring the nurse to an employee assistance

program, and referring the nurse to a treatment program), or report the nurse to the Board of Registered Nursing (BRN) (see Table 4).

Table 4

CNE's Management Decision for Alcohol and Drug Dependent Nurses

CNE's Decision	Alcohol Dependent		Drug Dependent	
	n	%	n	%
Allow to resign	2	1%	3	2%
Return to work	30	18%	23	14%
Refer to treatment	95	57%	95	57%
Report to BRN	5	3%	15	9%
Missing	35	21%	31	18%
Total	167	100%	167	100%

In summation of Research Question 1, it appeared that slightly more CNEs employed alcohol impaired (64%) than drug impaired nurses (61%), and CNEs had made decisions regarding both. Although no statistical comparison was made, the decisions regarding drug and alcohol impaired nurses appear quite similar.

Research Question 2

Research Question 2 was as follows: What is the relationship between the CNE's employment decision and the type of substance abused by the nurse? To answer this question, Item 4 and Item 9 on the survey were used. Item 4 asked, "As a chief nurse executive, when you make decisions about alcohol dependent nurses, is employment typically . . ." Item 9 asked, "As a chief nurse executive, when you make decisions about drug dependent nurses, is employment typically . . ."

The chi-square statistic could not be used due to small cell frequencies. Frequencies and percentages are shown in Table 5.

As seen in Table 5, 63% of the CNEs maintained alcohol impaired nurses; 49% of the CNEs maintained drug impaired nurses. Although no statistical comparison was possible between the two groups, the trend shows that higher percentages of CNEs terminated drug impaired nurses and higher percentages of CNEs maintained alcohol impaired nurses.

To further answer Research Question 2, Item 5 (How do you typically manage alcohol dependent nurses: resign, return, refer, or report) was cross-tabulated with Item 11B (reported importance of the type of substance used to a CNE's decision to terminate a nurse). The chi-square

Table 5

The CNE's Decision and Type of Substance Abused by the Nurse

CNE's Decision	Alcohol		Drugs	
	n	%	n	%
Maintained	105	63%	82	49%
Terminated following a Trial	35	21%	42	25%
Terminated Immediately	6	4%	26	16%
Missing	21	12%	17	10%
Total	167	100%	167	100%

statistic could not be used due to small cell frequencies. The frequencies and percentages are shown in Table 6.

The CNEs most frequently reported the type of substance was "very important" when the decision was to refer (n = 32, 78.0%). The CNEs also most frequently reported the type of substance was "not important" (68.2%) when the decision was to refer. CNEs most frequently reported the type of substance was "somewhat important" (68.2%) when the decision was to refer. All categories of importance show a similar pattern. Although the data did not meet the requirements

Table 6

Management Decisions and the Importance of the Substance With Nurses Dependent on Alcohol

Decision	Not Impt		Somewhat Impt		Very Impt		Undecided	
	n	%	n	%	n	%	n	%
Alcohol Impaired								
Allow to Resign	1	2.3%	0	0.0%	1	2.4%	0	0.0%
Return to Work	10	22.7%	13	29.5%	7	17.1%	0	0.0%
Refer to Treatment	30	68.2%	30	68.2%	32	78.1%	1	100.0%
Report	3	6.8%	1	2.3%	1	2.4%	0	0.0%
Total	44	100.0%	44	100.0%	41	100.0%	1	100.0%

Note. N = 130; 37 responses were missing.

for a statistical analysis, it seems that type of substance is not related to the decision with alcohol.

To further answer Research Question 2, Item 10 (How do you typically manage drug dependent nurses: resign, return, refer, or report?) was cross-tabulated with Item 11B (reported importance of the type of substance used to a CNE's decision to terminate a nurse). The chi-square statistic could not be used due to small cell frequencies. The frequencies and percentages are shown in Table 7.

The CNEs most frequently reported the type of substance was "not important" when the decision was to refer (n = 34,

Table 7

Management Decisions and the Importance of the Substance With Nurses Dependent On Drugs

Decision	Not Important		Somewhat Important		Very Important		Undecided	
	n	%	n	%	n	%	n	%
Alcohol Impaired								
Allow to Resign	0	0.0%	2	4.2%	1	2.6%	0	0.0%
Return to Work	7	15.6%	10	20.8%	5	12.8%	1	50.0%
Refer to Treatment	34	75.6%	30	62.5%	28	71.8%	1	50.0%
Report	4	8.8%	6	12.5%	5	12.8%	0	0.0%
Total	45	100.0%	48	100.0%	39	100.0%	2	100.0%

Note. N = 134; 33 responses were missing.

75.6%). The CNEs most frequently reported the type of substance was "somewhat important" (62.5%) when the decision was to refer. CNEs most frequently reported the type of substance was "very important" (71.8%) when the decision was to refer. All categories of importance show a similar pattern. It seems that type of substance is not related to the decision with drugs.

In summation of Research Question 2, the data suggest that CNEs' decisions to terminate impaired nurses were not related to the type of substance, alcohol or drugs. However, the data also suggest that in the CNEs'

administrative practice, there is a trend for CNEs to maintain alcohol impaired nurses more frequently, and terminate drug impaired nurses more frequently. This discrepancy may be due to the way in which the questions were asked. The trend toward maintaining alcohol impaired nurses concerned decisions to maintain or terminate. The questions that showed no trend related to type of substance asked specifically about terminating decisions only.

Research Question 3

The third research question was: What personal and institutional factors are associated with responses to (a) alcohol dependent nurses and (b) drug dependent nurses?

The first approach used the 11th item of the survey, which asked, "The following item refers to factors that may be associated with your decision, as Chief Nurse Executive, to terminate the employment of alcohol or drug dependent nurses. Please rate the importance of each of the following factors with respect to your employment decisions." The CNEs' responses were rated on a scale from 1 = not important to 3 = very important, with an option 4 = undecided. Hence, the first step was to determine how important, generally, CNEs thought the factor was in their decision to terminate an impaired nurse (see Table 8). These factors were (a) hospital policies, (b) type of substance used (see Table 9), (c) theft or diversion of drugs from patients (see Table

Table 8

Importance of Factors to a CNE's Decision to Terminate Employment of Alcohol or Drug Dependent Nurses

Factors	Percentages					
	Not Impt	Some-what Impt	Very Impt	Unde-cided	Mis-sing	Total
Hospital Policies	1.2%	28.1%	69.5%	0.0%	1.2%	100.0%
Type of Substance	31.2%	33.5%	31.7%	2.4%	1.2%	100.0%
Theft/Diversion	1.2%	10.2%	85.6%	1.2%	1.8%	100.0%
Potential Lawsuit	12.6%	37.1%	44.3%	5.4%	0.6%	100.0%
Characteristics (Competency/ Seniority) of the Dependent Nurse	20.4%	35.9%	38.9%	2.4%	2.4%	100.0%
Previous Experience with Impaired Nurse	18.0%	35.3%	38.3%	6.6%	1.8%	100.0%
Documentation of Impaired Practice	3.0%	12.6%	80.2%	3.6%	0.6%	100.0%
Impaired Nurse is in Denial	13.8%	22.2%	59.3%	3.0%	1.7%	100.0%

10), (d) potential lawsuit, (e) characteristics of the dependent nurses (competency, seniority, etc.), (f) previous experience with impaired nurse(s), (g) potential union grievance, (h) negative publicity for institution, (i) adequate staff/patient ratio, (j) documentation of impaired practice, (k) the impaired nurse is in denial, and (l) other. The factors rated very important in the termination of an impaired nurse by the greatest percentages of CNEs were (a) theft of or diversion of drugs from

patients (86%), (b) documentation of impaired practice (80%), and (c) hospital policies (70%).

Secondly, CNEs who decided about alcohol impaired nurses were compared with CNEs who decided about drug impaired nurses with regard to their ratings of importance. Unfortunately, because of the small number of CNEs who allowed nurses to resign without taking further action, chi-square tests were not possible. Thus, descriptive statistics, frequencies and percentages, were presented for CNEs deciding about alcohol impaired and drug impaired nurses (see Table 9). This table shows the importance ratings of CNEs separately for alcohol and drug impaired nurses.

In the two groups, the same percentage of CNEs felt that the type of impairment was somewhat or very important to their decision to allow the nurse to return to work (alcohol impaired: somewhat important = 43%, very important = 23%; drug impaired: somewhat important = 44%, very important = 22%). Relative to reporting the impaired nurse to the BRN, however, only 40% of CNEs making a decision about alcohol impaired nurses said the type of impairment was somewhat (20%) or very important (20%) in terminating the nurse. Of the CNEs making a decision about drug impaired nurses, 73% indicated the type of impairment was

Table 9

The Importance of Type of Substance in the CNEs' Management Response

Decision	Percentages				
	Not Impt	Some-what Impt	Very Impt	Unde-cided	Total
Alcohol Impaired					
Allow to Resign	50%	0%	50%	0%	100%
Return to Work	33%	43%	23%	0%	99.9%
Refer to Treatment	32%	32%	34%	1%	100.1%
Report	60%	20%	20%	0%	100%
Drug Impaired					
Allow to Resign	0%	67%	33%	0%	100%
Return to Work	30%	44%	22%	4%	99.9%
Refer to Treatment	37%	32%	30%	1%	100.1%
Report	27%	40%	33%	0%	100%

Note: Percentages may not equal 100% due to rounding.

somewhat (40%) or very important (33%). These data suggest that CNEs who report drug impaired nurses to the BRN are more likely to think the type of impairment is somewhat or very important to a decision relative to an impaired nurse.

Personal Factors

Personal factors possibly related to the CNEs' responses to alcohol and drug impaired nurses include knowledge, nursing curricula, attitudes, and gender. The

personal factors of knowledge and nursing curricula were addressed in Table 2.

Curricula. The next analysis investigated the relationship between the personal factor of the CNE's educational preparation to deal with an impaired nurse and the CNE's management decision relative to impaired nurses. Results pertaining to this analysis were presented in Table 10.

CNEs with curriculum preparation were more likely to maintain alcohol impaired nurses (87%), whereas only 70% of the CNEs without curriculum preparation maintained alcohol impaired nurses. CNEs with curriculum preparation were less likely to terminate alcohol impaired nurses after a trial (7%) than CNEs without curriculum preparation (26%). This was true for both drug and alcohol impaired nurses. CNEs with curriculum preparation were more likely to maintain drug impaired nurses (69%), whereas only 53% of the CNEs without curriculum preparation maintained drug impaired nurses. Nineteen percent of the CNEs with curriculum preparation terminated drug impaired nurses after a trial period, whereas 29% of the CNEs without curriculum terminated drug impaired nurses. When comparing alcohol and drug impaired nurses, CNEs were more likely to maintain alcohol impaired nurses (87%) and less likely to maintain drug impaired nurses (69%).

Table 10

Curriculum Preparation and the CNE's Response to Impaired Nurses

Decision	Curriculum Preparation			
	Yes		No	
	n	%	n	%
Alcohol Impaired				
Maintain	13	87%	92	70%
Terminate after trial	1	7%	34	26%
Terminate immediately	1	7%	5	4%
Total	15	101%	131	100%
Drug Impaired				
Maintain	11	69%	71	53%
Terminate after trial	3	19%	38	29%
Terminate immediately	2	13%	24	18%
Total	16	101%	133	100%

Note: Percentages may not equal 100% due to rounding.

Attitudes. The next analysis investigated the relationship between the personal factor of attitudes and management decisions relative to impaired nurses. The personal factors of attitudes were assessed by Items 18A through 18D, which presented four attitudinal statements

regarding impaired nurses: (a) Impaired nurses could recover if they wanted to; (b) I would hire an impaired nurse if monitored by the Board of Registered Nursing Diversion Program; (c) I have more negative feelings about drug impaired nurses than alcohol impaired nurses; and (d) To recover, impaired nurses must accept both the authority and discipline of others. Respondents chose one of four responses to the statements: (a) strongly disagree, (b) disagree, (c) agree, and (d) strongly agree (see Table 11). Over 70% of the CNEs agreed (51.5%) or strongly agreed (21.1%) with the statement, "Impaired nurses could recover if they wanted to."

Over 80% of the CNEs agreed (54.5%) or strongly agreed (27.5%) with the statement, "I would hire an impaired nurse if monitored by the BRN Diversion Program." Slightly over 16% disagreed (15.6%) or strongly disagreed (1.2%) with the statement.

Three fourths of the CNEs (76%) disagreed (46.1%) or strongly disagreed (29.9%) with the statement, "I have more negative feelings about drug impaired nurses than alcohol impaired nurses." Only 24% agreed (19.2%) or strongly agreed (4.8%).

The last statement measured the CNEs' responses to the Enlightenment Model (Brickman et al., 1982). Over 61% of the CNEs agreed (46.1%) or strongly agreed (15.1%) with the

Table 11

Attitudes Toward Impaired Nurses

Factor	Percentages				Missing	Total
	Strongly Disagree	Disagree	Agree	Strongly Agree		
Impaired nurses could recover if they wanted to.	3.6%	21.6%	51.5	21.0%	1.8	99.5%
I would hire an impaired nurse if monitored by the BRNDP.	1.2%	15.6%	54.5%	27.5%	1.2	100.0%
I have more negative feelings about drug impaired nurses than alcohol impaired nurses.	29.9%	46.1%	19.2%	4.8%	0.0	100.0%
To recover, impaired nurses must accept both the authority and discipline of others.	6.0%	27.5%	46.1%	15.0%	5.4	100.0%

Note: Percentages may not equal 100% due to rounding.

statement, "To recover, impaired nurses must accept both the authority and discipline of others."

Table 12 shows the cross-tabulation of the item measuring the enlightenment attitude and the CNEs' management responses. Among those CNEs who disagreed or strongly disagreed with the enlightenment attitude, the biggest difference was between the percentages of CNEs making a decision to immediately terminate alcohol impaired nurses (strongly disagree = 0%, disagree = 17%) and drug impaired nurses (strongly disagree = 12%, disagree = 23%). The differences between alcohol or drug impaired nurses in terms of percentages of CNEs who would maintain or terminate after a trial were very small.

Among those who agreed or strongly agreed with the enlightenment attitude, the percentages of CNEs who maintained or terminated after a trial were very similar for alcohol impaired (maintain, 63%; terminate after a trial, 60%) and for drug impaired nurses (maintain, 64%; terminate after a trial, 65%). In the group who terminated immediately, a higher percentage of the CNEs who agreed with the enlightenment model terminated alcohol impaired nurses (84%) than drug impaired nurses (66%). However, the number of CNEs who terminated alcohol impaired nurses immediately was so small (n = 5), the comparison may be unstable.

Table 12

Percentage of Each Management Response and Agreement with Enlightened Attitude Toward Impaired Nurses: "Impaired Nurses Must Accept Both Authority and Discipline of Others"

Decision	Unenlightened			Enlightened			
	Strongly Disagree	Disagree	Sub-Total	Agree	Strongly Agree	Sub-Total	Total
Alcohol Impaired							
Maintain	8%	29%	37%	48%	15%	63%	100%
Term after Trial	6%	34%	40%	46%	14%	60%	100%
Term Immediately	0%	17%	17%	67%	17%	84%	101%
Drug Impaired							
Maintain	5%	30%	35%	47%	17%	64%	99%
Term after Trial	5%	31%	36%	48%	17%	65%	101%
Term Immediately	12%	23%	35%	54%	12%	66%	101%

Note: Percentages may not equal 100% due to rounding.

Gender. The personal factor of the CNE's gender was cross-tabulated with the CNE's management decision regarding an impaired nurse (whether to allow to resign, return to

work, refer to treatment or to report to the BRN). Results for the factor of gender appear in Table 13.

It appeared that male and female CNEs were relatively similar in the way they treated alcohol impaired or drug impaired nurses. A slight difference was noted for male CNEs in that a greater percentage referred alcohol impaired nurses (88%) to treatment than drug impaired nurses (71%). This contrasted with female CNEs who were similar in the number who referred alcohol impaired (71%) and drug impaired (70%) nurses to treatment. A greater percentage of male CNEs allowed alcohol impaired nurses (13%) to resign than drug impaired nurses (0%), while the percentages for female CNEs were similar (1% and 2%, respectively).

Fewer male CNEs reported alcohol impaired nurses (0%) than drug impaired nurses (14%). Also, fewer female CNEs reported alcohol impaired nurses (4%) than drug impaired nurses (11%). Similar percentages of male and female CNEs referred drug impaired nurses to treatment (male = 71%, female = 70%).

Gender groups were compared for the CNEs' responses to alcohol impaired nurses. A higher percentage of male CNEs (13%) than female CNEs (1%) allowed these nurses to resign. A higher percentage of female CNEs (24%) than male CNEs (0%) allowed these nurses to return to work. A higher percentage of male CNEs (88%) than female CNEs (71%) referred these

Table 13

Percentage of CNEs, by Gender, and Their Management Responses

Decision	Male		Female	
	n	%	n	%
Alcohol Impaired				
Allow to Resign	1	12.5%	1	0.8%
Return to Work	0	0.0%	30	24.2%
Refer to Treatment	7	87.5%	88	71.0%
Report	0	0.0%	5	4.0%
Total	8	100.0%	124	100.0%
Drug Impaired				
Allow to Resign	0	0.0%	3	2.3%
Return to Work	1	14.3%	22	17.1%
Refer to Treatment	5	71.4%	90	69.8%
Report	1	14.3%	14	10.9%
Total	7	100.0%	129	100.1%

Note. Percentages may not equal 100% due to rounding.

nurses to treatment. A higher percentage of female CNEs (4%) than male CNEs (0%) reported these nurses.

Gender groups were compared for the CNEs' responses to drug impaired nurses. A similar percentage of female CNEs (2%) and male CNEs (0%) allowed the nurses to resign. A similar percentage of female CNEs (17%) and male CNEs (14%) allowed nurses to return to work. A similar percentage of male CNEs (71%) and female CNEs (70%) referred nurses to treatment. A similar percentage of male CNEs (14%) and female CNEs (11%) reported the nurses.

Responses by male and female CNEs were compared for the two categories of impairment (alcohol impaired and drug impaired). A higher percentage of male CNEs allowed alcohol impaired nurses (12.5%) to resign than drug impaired nurses (0%). More male CNEs allowed drug impaired (14.3%) to return to work than alcohol impaired nurses (0%). More male CNEs (87.5%) referred alcohol impaired nurses for treatment than drug impaired nurses (71.4%). A higher percentage (14.3%) of male CNEs reported drug impaired nurses (14.3%) while fewer (0%) of male CNEs reported alcohol impaired nurses.

A higher percentage of female CNEs allowed alcohol impaired nurses (24.2%) than allowed drug impaired nurses (17.1%) to return to work. Female CNEs were similar in their actions regarding referring impaired nurses for treatment (alcohol impaired = 71.0%, drug impaired = 69.8%).

A higher percentage of female CNEs reported drug impaired (10.9%) than reported alcohol impaired (4.0%) nurses.

Institutional Factors

Institutional factors analyzed were resources and practices for dealing with impaired nurses, which included (a) an employee assistance program (EAP), (b) written policies, (c) a written policy provision for relapse, (d) unwritten policies, (e) employee insurance for treatment, and (f) employee disability coverage during treatment (see Table 14).

Only 52% of the hospitals had a written policy for impaired nurses, with 48% of the hospitals lacking a written policy. Only 26% of the policies had a provision for relapse, and only 69% of the hospitals had an EAP. Insurance benefits included insurance coverage providing treatment (77%) and disability insurance (74%).

Written policy. Table 15 shows the cross-tabulations of the existence of a specific written policy for dealing with impaired nurses and the CNEs' management decisions. There was a slight tendency for CNEs whose hospitals had no written policy to be less supportive of drug impaired nurses and more supportive of alcohol impaired nurses in all categories. Alcohol impaired nurses were maintained by CNEs (44%) while drug impaired nurses were maintained by a lower

Table 14

Institutional Factors

Factor	Yes		No		NA		Miss-ing	Total
	n	%	n	%	n	%		
Employee Assistance Program?	115	69.3%	51	30.7%	--	--	1	100%
Written policies for impaired RNs?	85	51.8%	79	48.2%	--	--	3	100%
Written relapse policy?	41	25.5%	54	33.5%	66	41.0%	6	100%
Unwritten policies for impaired RNs?	81	49.4%	83	50.6%	--	--	3	100%
Rehabilitation insurance?	125	76.7%	38	23.3%	--	--	4	100%
Disability insurance during treatment?	116	73.9%	41	26.1%	--	--	10	100%

percentage of CNEs (40%). Alcohol impaired nurses were terminated immediately by 50% of the CNEs, whereas drug impaired nurses were terminated immediately by 58% of the CNEs when there was no written policy.

In summation of Research Question 3, the data suggest the following regarding personal factors. Past experience

Table 15

Percentage of Each CNE's Management Response with Hospital's Specific Written Policy

Decision	Written Policy?				
	Yes		No		Total
	n	%	n	%	
Alcohol Impaired					
Maintain	58	56%	45	44%	100%
Terminate after trial	17	50%	17	50%	100%
Terminate immediately	3	50%	3	50%	100%
Drug Impaired					
Maintain	48	60%	32	40%	100%
Terminate after trial	20	49%	21	51%	100%
Terminate immediately	11	42%	15	58%	100%

is the primary source of knowledge for CNEs regarding impaired practice. The majority of the CNEs did not feel that the curriculum from their highest degree prepared them to deal with impaired nurses. There appeared to be a trend for more CNEs who did not agree with the enlightenment statement to terminate drug impaired nurses than alcohol

impaired nurses. There was a slight difference in male CNEs referring more alcohol impaired nurses to treatment than drug impaired nurses, whereas female CNEs behaved similarly for both groups.

In summation of institutional factors, the data suggest that slightly over half of the hospitals had a written policy for dealing with impaired nurses. Only 26% of the policies had a provision for relapse. Around 75% of the hospitals had insurance coverage for treatment and disability insurance. In hospitals that had no written policy for managing impaired nurses, there was a trend to be more supportive of alcohol impaired nurses than drug impaired nurses, in that more alcohol impaired nurses were maintained and more drug impaired nurses were terminated. In summation of the most important factors associated with termination of an impaired nurse, (a) theft or diversion of drugs from patients, (b) documentation of impaired practice, and (c) hospital policies were reported in order of importance.

Chapter 5

CONCLUSIONS AND RECOMMENDATIONS

This was a descriptive study with a cross-sectional survey design intended to examine responses of Chief Nurse Executives (CNEs) in acute care hospitals to impaired nurses. The questionnaire was developed by the researcher based on a survey by Hughes (1989). Of the 250 CNEs sent the survey, 167 (67%) returned surveys for analysis.

Conclusions

This study analyzed the reported responses of CNEs to nurses whose professional functioning was impaired by use of (a) alcohol and/or (b) drugs other than alcohol. Sixty-four percent of the CNEs were willing to employ alcohol impaired nurses, whereas 61% of the CNEs were willing to employ drug impaired nurses. CNEs had made decisions relative to the employment and management of both. A greater number of CNEs reported drug impaired nurses to the BRN than reported alcohol impaired nurses (9% and 3%, respectively). The decisions appear similar, with a slight tendency for more supportive responses to alcohol impaired nurses, to Hughes's (1989) study results.

The study also analyzed the relationship between the CNE's employment decision and the type of substance abused by the nurse. When considering all employment decision

options, 16% of the CNEs terminated drug impaired nurses immediately, whereas only 4% of the CNEs terminated alcohol impaired nurses immediately. This trend replicates Hughes's (1989) finding that CNEs, considering all employment decisions, were more likely to terminate drug dependent nurses than alcohol dependent nurses, particularly when employment was terminated immediately. Sixty-three percent of the CNEs in the current study maintained alcohol impaired nurses, while 49% of the CNEs maintained drug impaired nurses. Sixty-five percent of the CNEs in Hughes's (1989) study maintained alcohol impaired nurses, and 31% of the CNEs maintained drug impaired nurses.

Sowa and Cutter (1974) reported hospital staff less positive in attitudes toward drug addicts than toward alcoholics. Cannon (1987) found that alcohol impairment in nurses was viewed more positively than drug impairment. The reported behaviors of CNEs in this study may be an indication of less positive actions toward drug impaired nurses than alcohol impaired nurses.

The CNEs in this study reported that there was no relationship between substance abused by the nurse and termination decisions. This finding may be biased due to the wording of the question or to the CNE's desire to respond with a socially acceptable answer. Hughes (1989) found a similar trend in CNEs' self-reporting attitudes,

which did not correlate with their employment responses. Finally, this study analyzed the personal and institutional factors associated with responses to alcohol and drug dependent nurses.

Personal Factors

CNEs in this study indicated that their primary source of information regarding impaired nurses was past experience, not formal education or the BRN. This finding has ramifications if the CNE's past experience has been negative and/or limited in scope. Only 20% of the CNEs in this study listed formal education (courses, continuing education, or inservice) as a primary source of knowledge. As a whole, members of the helping professions are not knowledgeable about alcohol and drug impairment or treatment (Green, 1984; Isler, 1978). The nursing profession lacks information regarding nursing impairment (Bissell & Jones, 1981). The trend of past experience supplanting education as a primary source of information does not augur well for change.

Of the CNEs in this study, 89% indicated that the curricula of their highest degree programs did not prepare them to respond to impaired practice. Although since 1985 the BRN has required training in the detection and treatment of impaired practice, it is possible that the majority of the CNEs in this study matriculated prior to 1985 and thus

were not provided with appropriate preparation. Hoffman and Heinemann (1987) found a common practice of nursing programs allocating one to five instructional hours to the topic of drug and alcohol abuse, which CNEs found inadequate. Although education has the ability to bring about change, the trends in this study indicate that education has fallen short in equipping CNEs to respond to impaired nurses.

Several personal attitudes were explored. Eighty-six percent of the CNEs were willing to hire an impaired nurse if the nurse was monitored by the BRN Diversion Program. The CNEs in this study may have been influenced by the Diversion Program, which has as its goals identification, treatment, and rehabilitation of the impaired nurse to assure that the nurse is competent to return to practice (California Board of Registered Nursing, 1984a). The CNEs in this study may be in fact adhering to the intent of the ANA, BRN, and CNA to advocate treatment and rehabilitation, so that the impaired nurse may safely return to work.

An attitudinal statement assessed self-reported prejudice. The large majority of CNEs in this study (96%) disagreed with the statement, "I have more negative feelings about drug impaired nurses than alcohol impaired nurses." There was a consistent difference in the way CNEs in this study treated alcohol impaired and drug impaired nurses. The CNEs' behavior may not reflect their self-reported

attitudes as indicated on this item. The CNEs' responses may represent a socially desirable, politically correct response rather than a true response.

CNEs' attitudes appeared to be biased against drug impaired nurses. CNEs who disagreed with the enlightenment statement (as defined by Brickman et al., 1982) appeared more likely to terminate drug impaired nurses.

A final personal factor analyzed was the CNEs' gender. The findings regarding male and female CNEs were different in some respects. Of the male CNEs, 14% reported alcohol impaired nurses and 0% reported drug impaired nurses. More male CNEs referred alcohol impaired nurses than referred drug impaired nurses (87.5% and 71.4%, respectively). More male CNEs allowed alcohol impaired nurses than allowed drug impaired nurses to resign (12.5% and 0%, respectively). This may reflect a different attitude of male CNEs from that of female CNEs toward women drinking alcohol. This finding was similar to that reported by Hughes (1989). The aspect of the CNEs' gender as it relates to management of impaired nurses has not been well researched in the literature.

Institutional Factors

The CNEs in this study indicated that 52% of their hospitals had a specific written policy for dealing with impaired nurses. Hughes (1989) found that fewer than 50% of the CNEs were at institutions with such a policy.

Fewer CNEs in this study who were employed at hospitals with a written policy (43%) reported immediate termination of drug impaired nurses than did CNEs at hospitals without such a policy (58%). In hospitals with policies, 60% of the CNEs retained drug impaired nurses. In hospitals without policies, 40% of the CNEs retained drug impaired nurses. Hughes (1989) stated that CNEs employed by institutions with written policies were more likely to maintain employment or be supportive of drug dependent nurses. Correction of policy deficits provides structure for attitudinal and behavioral change toward impaired nurses (Gelfand, Long, McGill, & Sheerin, 1990). The trend found in the current study for CNEs to be more supportive when there is a policy in place speaks well for the power of written policies.

Model policies address relapse, providing support and consequences (Hughes, 1989). Only 26% of the written policies in this study had a relapse provision. Research indicates that nurses are a good treatment risk, with a low rate of relapse (Sullivan, 1987; Valentine, 1988; Yeary, 1987). There was a trend for CNEs in this study to ignore the issue of relapse in written policies. Ignoring the research findings regarding nurses' being a good treatment risk is neither helpful to the impaired nurse nor to the CNE.

In this study, 64% of the CNEs had employed alcohol impaired nurses, whereas 61% had employed drug impaired nurses. Similar findings were reported by Hughes (1989).

CNEs indicated that when terminating an impaired nurse, the following personal or institutional factors were most important: (a) theft and diversion of drugs, (b) documentation of impaired practice, and (c) hospital policies. From a list of 12 factors, CNEs in the current study chose theft and diversion of drugs as the most important in the decision to terminate an impaired nurse; 85.6% of the CNEs rated this item as very important; and 10.2% rated this item as somewhat important.

Documentation of impaired practice was rated as the second most influential factor in the current study related to terminating an impaired nurse. This topic has not been well researched in the literature in terms of how it influences the CNE's employment decisions.

The third most influential factor was hospital policies. Sullivan (1987; also cited in Hughes, 1989) reported that many hospitals have policies requiring immediate termination for theft of controlled substances, which is a federal offense. Theft and diversion of drugs violates a basic professional mandate; thus, nurses who divert drugs are less likely to receive supportive

treatment. Similar motivations may be underlying the responses of CNEs in this study.

The most important conclusion from this study appears to be the trend for less supportive responses of CNEs to drug dependent nurses compared to alcohol dependent nurses. The majority of the CNEs in this study had encountered chemically impaired practice while functioning as chief nurse administrators.

Recommendations

1. Further study should be made to determine if CNEs are in fact employing drug and alcohol impaired nurses in recovery. Results could be compared with findings prior to 1985 when the BRN Diversion Program was implemented. If so, what are the key factors associated with a CNE's willingness to employ an impaired nurse in recovery?

2. This study indicates that drug impaired nurses were more likely than alcohol impaired nurses to be terminated immediately, as did Hughes's (1989) study. Still to be explored is the motivation for this trend. A study should be conducted that more directly focuses on CNEs' motivation for maintaining or terminating an impaired nurse.

3. In this study, data suggest that male and female CNEs may differ in their responses to impaired nurses. Further study should be done with larger samples of male and

female CNEs so that valid comparisons can be made to determine how gender affects CNEs' responses.

4. This study made no attempt to determine the decision-making process concerning employment decisions. Future researchers should explore the process and determine who and what are involved.

5. In-depth interviews with CNEs would provide more specific data concerning the interplay of personal and institutional factors.

It is hoped that continued research will test the efficacy of King's model to provide CNEs, educators, therapists, and the nursing profession as a whole with a framework to guide nursing practice so that optimal care is provided for both the impaired nurse and the patient population for which each CNE is ultimately responsible.

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APPENDIX A

Cover Letter, Participation Agreement

SJSU SAN JOSE STATE UNIVERSITY

A campus of The California State University

School of Applied Arts and Sciences • Department of Nursing • Graduate Program
One Washington Square • San Jose, California 95192-0057 • 408/924-3134

July 26, 1991

Dear

I invite your participation in a study which will take approximately 5-8 minutes of your time.

The study examines chief nurse executive's responses to impaired nurses and the personal and institutional factors associated with the responses.

Please complete the questionnaire and signed consent form and return them in the enclosed envelope -- if at all possible, within the next week. A copy of the abstract is available upon request.

I could not conduct this study without the kind of expert opinions you can provide. I would very much appreciate your help with it. The overall task requires only a modest amount of time from each participant. Your name, and the name of the hospital, will not be identified. Return envelopes are coded to facilitate follow-up mailing. All reports of data will be presented as aggregate statistics only.

I am currently enrolled in a Master of Science Program at San Jose State University, with an emphasis on Nursing Administration.

This survey must be completed by a nurse administrator functioning in the role of chief nurse executive or the equivalent. Please forward, if necessary.

Thank you,

Coleen Saylor, Ph.D.
Advisor
(408) 924-2905

Janice Read Klein, RNCS
Master's Candidate
(415) 593-6623

SJSU SAN JOSE STATE UNIVERSITY

A campus of The California State University

School of Applied Arts and Sciences • Department of Nursing • Graduate Program
One Washington Square • San Jose, California 95192-0057 • 408/924-3134

AGREEMENT TO PARTICIPATE IN RESEARCH

SAN JOSE STATE UNIVERSITY

RESPONSIBLE INVESTIGATOR: Janice Read Klein

TITLE OF PROTOCOL: CHIEF NURSE EXECUTIVE'S RESPONSES TO IMPAIRED NURSES

I have been asked to participate in a research study that is investigating chief nurse executive's responses to nurses impaired by chemical dependency. The results of this study should further our understanding of the personal and institutional factors that are associated with the chief nurse executive's (CNE's) responses to impaired nurses.

I understand that:

(1) I will be asked to complete a written questionnaire at my hospital, which will take approximately 5 to 8 minutes to complete.

(2) There are no anticipated risks.

(3) There are benefits to me in that completion of this study will bring to my awareness the many factors which are associated with responses to an impaired nurse, as a CNE. In addition, I will receive a copy of the abstract upon request.

(4) There are no alternative procedures.

(5) The results of this study will be used in a Master's thesis and may be published in professional journals. Any information from this study that can be identified will remain confidential, and will be disclosed only with my permission. Data will be published as aggregate statistics. Neither my name nor the name of the hospital will be used.

(6) There will be no monetary compensation for subjects.

SJSU SAN JOSE STATE UNIVERSITY

A campus of The California State University

School of Applied Arts and Sciences • Department of Nursing • Graduate Program
One Washington Square • San Jose, California 95192-0057 • 408/924-3134

(7) Any questions about my participation in this study will be answered by Janice Read-Klein (415) 592-6672. Complaints about the procedures may be presented to Colleen Saylor, Ph.D., Advisor (408) 924-2905, Dr. Virgil Parsons, Chair, Department of Nursing (408) 924-3182. For questions or complaints about subject's rights, or in the event of a research related injury, contact Dr. Serena Stanford (Associated Academic Vice President for Graduate Studies and Research), (408) 924-2480.

(8) My consent is given voluntarily without being coerced. I may refuse to participate in this study or in any part of this study, and I may withdraw at any time, without prejudice to my relations with San Jose State University.

(9) I have received a copy of this consent form for my file.

I HAVE MADE A DECISION WHETHER OR NOT TO PARTICIPATE. MY SIGNATURE INDICATES THAT I HAVE READ THE INFORMATION PROVIDED ABOVE AND THAT I HAVE DECIDED TO PARTICIPATE.

_____ _____

Date Subject's Signature

_____

Investigator's Signature

APPENDIX B

Instrument

Professional Impairment Survey

Please place a check mark in the space provided for each item to indicate your response.

The following items pertain to alcohol impaired nurses.

1. In the past five years have you made any disciplinary decisions about registered nurses whose professional functioning was impaired by alcohol dependency?

   ☐ Yes ☐ No

2. Have you employed any nurses who are recovering from alcohol dependency?

   ☐ Yes ☐ No

3. Have you modified any alcohol dependent nurses' work environment or work responsibilities?

   ☐ Yes ☐ No ☐ Not applicable

4. As a chief nurse executive, when you make decisions about alcohol dependent nurses, is employment typically (check only one)

   ☐ Maintained?
   ☐ Terminated following a trial period?
   ☐ Terminated immediately?

5. How do you typically manage alcohol dependent nurses? (check only one)

   ☐ Allow nurse to resign before action taken
   ☐ Allow nurse to return to work following treatment
   ☐ Refer nurse to the California Diversion Program
   ☐ Refer nurse to employee assistance program
   ☐ Refer nurse to treatment program
   ☐ Report nurse to state licensing board
   ☐ Other _____

The following items pertain to drug impaired nurses.

6. In the past five years have you made any disciplinary decisions about registered nurses whose professional functioning was impaired by drug dependency?

   ☐ Yes ☐ No

7. Have you employed any nurses who are recovering from drug dependency?

   ☐ Yes ☐ No

Over please ➥

8. Have you modified any drug dependent nurses' work environment or work responsibilities?

☐ Yes ☐ No ☐ Not applicable

9. As a chief nurse executive, when you make decisions about drug dependent nurses, is employment typically (check only one)

☐ Maintained?
☐ Terminated following a trial period?
☐ Terminated immediately?

10. How do you typically manage drug dependent nurses? (check only one)

☐ Allow nurse to resign before action taken
☐ Allow nurse to return to work following treatment
☐ Refer nurse to the California Diversion Program
☐ Refer nurse to employee assistance program
☐ Refer nurse to treatment program
☐ Report nurse to state licensing board
☐ Other _____

The following item refers to factors that may be associated with your decision, as chief nurse executive, to terminate the employment of alcohol or drug dependent nurses.

11. Please rate the importance of each of the following factors with respect to your employment decisions.

1 = Not important 2 = Somewhat important 3 = Very important 4 = Undecided

	1	2	3	4
A. Hospital policies	☐	☐	☐	☐
B. Type of substance used (alcohol, narcotics)	☐	☐	☐	☐
C. Theft or diversion of drugs from patients	☐	☐	☐	☐
D. Potential law suit	☐	☐	☐	☐
E. Characteristics of dependent nurses (competency, seniority, etc)	☐	☐	☐	☐
F. Previous experience with impaired nurse(s)	☐	☐	☐	☐
G. Potential union grievance	☐	☐	☐	☐
H. Negative publicity for institution	☐	☐	☐	☐
I. Adequate staff/patient ratio	☐	☐	☐	☐
J. Documentation of impaired practice	☐	☐	☐	☐
K. The impaired nurse is in denial	☐	☐	☐	☐
L. Other _____	☐	☐	☐	☐

This section pertains to institutional factors affecting impaired nurses.

12. Does your hospital have an employee assistance program?

☐ Yes ☐ No

13. Does your hospital have specific written policies for dealing with impaired nurses?

☐ Yes ☐ No

14. Does your written policy include a provision for relapse?

☐ Yes ☐ No ☐ Not applicable

15. Does your hospital have 'unwritten' policies for dealing with impaired nurses?

☐ Yes ☐ No

16. Does your hospital provide its own employee insurance coverage for treatment of impaired nurses?

☐ Yes ☐ No

17. Does your hospital provide employee disability coverage during treatment?

☐ Yes ☐ No

This section pertains to personal factors affecting impaired nurses.

18. Please indicate the extent to which you agree or disagree with the statements below.

1 = Strongly disagree 2 = Disagree 3 = Agree 4 = Strongly Agree

	1	2	3	4
A. Impaired nurses could recover if they wanted to.	☐	☐	☐	☐
B. I would hire an impaired nurse if monitored by the Board of Registered Nurses Diversion Program.	☐	☐	☐	☐
C. I have more negative feelings about drug impaired nurses than alcohol impaired nurses.	☐	☐	☐	☐
D. To recover, impaired nurses must accept both the authority and discipline of others.	☐	☐	☐	☐

This last section pertains to background information.

19. ____ Your age?

20. Your gender? ☐ Male ☐ Female

Over please ➥

Background Information Continued.

21. Are you presently functioning in the role of Chief Nurse Executive (highest ranking nurse administrator)?

☐ Yes ☐ No

22. What is your highest nursing degree?

☐ Diploma
☐ Associate Degree
☐ Baccalaureate
☐ Masters
☐ Doctorate

23. Did the curricula (from your highest degree) prepare you to respond to impaired nurses?

☐ Yes ☐ No

24. Indicate your primary source of information regarding impaired nurses (check only one).

☐ Formal Courses
☐ Continuing Education
☐ Inservice
☐ Professional Journals
☐ AA/NA meetings
☐ Board of Registered Nursing
☐ Past Experience
☐ Other _____

25. ____ Number of beds in your hospital?

26. ____ Number of registered nurses employed in your hospital?

27. Is your hospital (check all that apply)

☐ Public
☐ Private
☐ Teaching institution
☐ Other _____

Please return in enclosed envelope by August 8th 1991 to:

Janice Read Klein, R.N.C.S.
2311 Coronet Blvd.
Belmont, CA 94002

Thank You

APPENDIX C

Hughes Questionnaire

Professional Impairment Study
(Hughes, 1989)

Please circle one answer code number for each question unless otherwise instructed.

1. In recent years the topic of drug and alcohol problems among health professionals has received increasing attention. Do you believe that the number of nurses with drug and/or alcohol problems is less than, greater than, or about the same as it was ten years ago?

   Less that it was ten years ago 1

   Greater than it was ten years ago 2

   About the same as it was ten years ago . . 3

2. Since you have been a nurse executive (in any institution), how many nurses (RNs or LPNs) have you dealt with who had or you suspected of having drug or alcohol problems that interfered with their professional functioning? (Please give your best estimate if you are uncertain about the number).

   Enter a number (if none, write "0" and skip to Q. 6) . _____

3a. In the past five years have you made a disciplinary decision about a registered nurse whose professional functioning was impaired by alcohol dependency?

   Yes 1

   No (skip to Q. 4a) 2

(IF YES:)

   b. How many nurses? (enter number) . . . . . _____

   c. In the most recent case in which you made a decision about an alcohol dependent nurse, was employment

      maintained? 1

      terminated following a trial period? . . . 2

      terminated immediately? 3

d. Was this alcohol dependent nurse (circle all that apply)

asked to resign? 01

reported to state licensing board? 02

referred to treatment? 03

referred to an employee assistance program? . 04

referred to the peer assistance network for nurses (PANN)? 05

allowed to work at the same hospital while monitored by nursing administration or an employee assistance program? 06

allowed to return to work at the same hospital following treatment? 07

allowed to resign before action taken? 08

terminated following failure to comply with agreement/contract? 09

Comments?_____

_____

_____

4a. In the <u>past five years</u> have you made a disciplinary decision about a registered nurse whose professional functioning was impaired by drug dependency?

Yes 1

No (skip to Q. 5a) 2

(IF YES:)

b. How many nurses (enter number) . . . . . _____

c. In the <u>most recent case</u> in which you made a decision about an alcohol dependent nurse, was employment

maintained? 1

terminated following a trial period? 2

terminated immediately? 3

d. Was this drug dependent nurse (circle all that apply)

asked to resign? 01

reported to state licensing board? . . . 02

referred to treatment? 03

referred to an employee assistance program? 04

referred to the peer assistance network for nurses (PANN)? 05

allowed to work at the same hospital while monitored by nursing administration or an employee assistance program? 06

allowed to return to work at the same hospital following treatment? 07

allowed to resign before action taken? . 08

terminated following failure to comply with agreement/contract? 09

Comments?_____

_____

_____

e. Did this nurse (circle all that apply)

take drugs from hospital supplies? 1
divert drugs from patients? 2
use controlled substances (e.g., narcotics)?3

5a. In the past five years have you had any professional experience with a registered nurse whose professional functioning was impaired but whose alcohol or drug dependence was <u>suspected</u>, <u>not confirmed</u>?

Yes 1

No (skip to Q. 6) 2

(IF YES:)

b. How many nurses? (enter number) . . . . . _____

c. Please describe briefly what actions were taken in the most recent case where alcohol or drug dependency was suspected.

_____

_____

_____

6. Following are some factors that may influence a CNE's decision to maintain or to terminate the employment of a drug or alcohol dependent nurse. Please rate each of the factors according to how important you believe it is in influencing this decision.

	NOT AT ALL IMPORTANT	SOMEWHAT IMPORTANT	VERY IMPORTANT
Hospital policies	1	2	3
State laws/regulations . .	1	2	3
Type of substance used (e.g., alcohol, non-narcotic, narcotic)	1	2	3
Theft of drugs involved . .	1	2	3
Diversion of drugs from patients involved	1	2	3
Circumstances surrounding the development of the dependency (e.g., following medical or surgical condition) . . .	1	2	3
Characteristics of dependent nurse (e.g., previous level of competence, seniority) .	1	2	3
CNE's attitudes toward alcohol/drug dependency . .	1	2	3
Whether previous experience with recovering alcohol/drug dependent nurse(s) was positive or negative . . .	1	2	3
Whether the nurse is a member of a union . .	1	2	3

	NOT AT ALL IMPORTANT	SOMEWHAT IMPORTANT	VERY IMPORTANT
Availability of resources for referral	1	2	3
Nursing supply	1	2	3
Other factors (please specify)			
_____	1	2	3
_____	1	2	3

7. Please list (in order of importance the three factors you believe to be most influential in determining CNE's decisions to maintain or terminate the employment of alcohol/drug dependent nurses.

1st _____

2nd _____

3rd _____

The following items are related to your beliefs about why a nurse executive might choose not to report.

8. When nurse executives do not report a nurse whose functioning is impaired by the use of drugs and/or alcohol it is because they:

		STRONGLY DISAGREE 1	DISAGREE 2	AGREE 3	STRONGLY AGREE 4
a.	fear personal lawsuit . .	1	2	3	4
b.	fear that the nurse's license will be revoked .	1	2	3	4
c.	believe that if warned of the potential consequences the nurse will stop using drugs/alcohol	1	2	3	4
d.	hope that with time the situation might improve without intervention . .	1	2	3	4

		STRONGLY DISAGREE 1	DISAGREE 2	AGREE 3	STRONGLY AGREE 4
e.	choose to refer to treatment and monitor the alcohol/drug dependent nurse's recovery	1	2	3	4
f.	believe that the evidence is not strong enough to warrant action	1	2	3	4
g.	wish to avoid time consuming and expensive investigatory procedures and hearings .	1	2	3	4
h.	feel intimidated by investigators from state licensing board	1	2	3	4
i.	wish to avoid negative publicity toward the institution	1	2	3	4
j.	lack institutional support	1	2	3	4
k.	are reluctant to acknowledge that alcohol/drug problems exist among nursing staff at their institution	1	2	3	4
l.	wish to avoid a union grievance	1	2	3	4
m.	feel unprepared to deal with an alcohol/drug dependent nurse	1	2	3	4
n.	others (please specify)				
	_____	1	2	3	4
	_____	1	2	3	4

Questions 9-18 deal with factors related to the hospital's handling of drug/alcohol dependent nurses. EVEN IF YOU HAVE NEVER MADE A

DECISION ABOUT A DRUG OR ALCOHOL DEPENDENT NURSE, PLEASE ANSWER THESE QUESTIONS. If your most recent experience(s) with drug and/or alcohol dependent nurses was at a previous hospital, please answer about that hospital.

9. Was your most recent experience(s) at your current or a previous hospital?

Current hospital 1

Previous hospital 2

10. Does the hospital have an employee assistance program (EAP)?

Yes 1

No (skip to Q. 11a) 2

(IF YES:)

b. Is the EAP housed inside or outside the hospital?

housed inside 1
housed outside 2

c. Is there someone working with the EAP who has special training in alcohol/drug dependency?

Yes 1

No 2

Don't know 3

11a. Does the hospital have specific written policies or procedures for dealing with alcohol/drug dependent nurse employees?

Yes 1

No (skip to Q. 12a) 2

(IF YES:)

b. Please describe briefly _____

_____

_____

c. Does the policy include a provision for relapse?

Yes 1

No (skip to Q. 11e) 2

(IF YES:)

d. Please describe briefly _____

_____

_____

e. Has the policy ever been used in deciding response for a drug or alcohol dependent nurse?

Yes 1

No 2

12a. Does the hospital have "unwritten" policies for dealing with drug/alcohol dependent nursing employees?

Yes 1

No (skip to Q. 13) 2

(IF YES:)

b. Breifly describe the unwritten policy _____

_____

_____

13. In working out a strategy for dealing with a nurse who is suspected or confirmed to be alcohol or drug dependent, which of the following people or departments would most likely be involved (circle all that apply)

Chief nurse executive 01

Middle-level nurse administrators 02

Chief executive officer of hospital . . . 03

Human resources/personnel dept 04

Employee assistance program 05

Hospital attorney 06

Pharmacy 07

Other (please specify)

_____ . . . ___

14. Does the hospital provide employee insurance coverage for treatment of drug/alcohol dependency?

Yes 1

No 2

15. Does the hospital provide employee disability coverage during treatment for drug/alcohol dependency?

Yes 1

No 2

16a. Has the hospital employed any nurses who are recovering from drug dependency?

Yes 1

No (skip to Q. 17a) 2

Don't know (skip to Q. 17a) 3

(IF YES:)

b. Are modifications made in these nurses' work environment or work responsibilities?

Yes 1

No (skip to Q. 17a) 2

(IF YES:)

c. Which of the following modifications are made? (circle all that apply).

No handling of narcotics 01

Supervised handling of narcotics 02

Assignment to unit with little or no drug availability 03

Unannounced blood/urine screens 04

No floating to other units 05

No rotating shift work 06

Others (please specify)

_____ . . . ____

_____ . . . ____

17a. Has the hospital employed any nurses who are recovering from alcohol dependency?

Yes 1

No (skip to Q. 18) 2

Don't know (skip to Q. 17) 3

(IF YES:)

b. Are modifications made in the recovering alcohol dependent nurses' work environment or work responsibilities?

Yes 1

No (skip to Q. 18) 2

(IF YES:)

c. Please describe briefly what modifications are made.

_____

_____

_____

18. In general, how satisfied or dissatisfied are you with the hospital's policies about and/or handling of drug and alcohol problems among nurses?

Very satisfied (no improvement needed). . 1

Generally satisfied (improvement needed in some areas) 2

Dissatisfied (major improvement needed) . 3

(Please comment): _____

_____

19. Below are sources of information about drug and/or alcohol dependency among nurses.

a. Please indicate <u>how</u> <u>much</u> you have participated in each of the following:

Formal coursework (enter number of courses taken) . . . . _____

Continuing education offerings (enter number of clock hours attended) . . . . . _____

Hospital inservice programs (enter number of clock hours attended) . . . . . _____

Alcoholics/Narcotics Anonymous (enter number of meetings attended) . . . . . _____

b. Please indicate how helpful the following sources of information have been in contributing to your understanding of drug/alcohol dependency among nurses?

	NOT AT ALL HELPFUL	SOMEWHAT HELPFUL	VERY HELPFUL	NOT USED
Formal coursework . .	1	2	3	7
CEU offerings	1	2	3	7
Inservice programs .	1	2	3	7
AA/NA meetings . . .	1	2	3	7
Professional books and journals	1	2	3	7
Peer Assistance Network	1	2	3	7
State board of nursing	1	2	3	7
Nonprofessional media (newspapers, T.V., etc.)	1	2	3	7

	NOT AT ALL HELPFUL	SOMEWHAT HELPFUL	VERY HELPFUL	NOT USED
Informal communication with other CNEs . . .	1	2	3	7
Past experience with alcohol/drug dependent nurses	1	2	3	7
Others (please specify)				
_____	1	2	3	7
_____	1	2	3	7

20. How well informed do you believe you are about alcohol/drug dependency among nurses?

Well informed 1

Somewhat informed 2

Hardly informed at all 3

21. How well informed do you believe you are about state laws related to alcohol/drug dependency among nurses (e.g., the Illinois Nurse Practice Act)?

Well informed 1

Somewhat informed 2

Hardly informed at all 3

The next two questions seek your views about how much responsibility alcohol/ drug dependent nurses have for developing and for overcoming their dependency. Please circle the number that best reflects your views.

22. Some people believe that, in general, alcohol/drug dependent nurses are responsible for the development of their dependency, while others believe that they are mainly victims of circumstance. In general, how much responsibility do you believe alcohol/drug dependent nurses have for causing their dependency?

NO RESPONSIBILITY TOTAL RESPONSIBILITY

1 2 3 4 5

23. Some people believe that, in general, alcohol/drug dependent nurses cannot overcome their dependency by themselves, while other people believe that they must rely mainly on themselves. In general, how much responsibility do you believe alcohol/drug dependent nurses have for overcoming their dependency?

NO RESPONSIBILITY				TOTAL RESPONSIBILITY
1	2	3	4	5

24. The following statements seek your views of how alcohol/drug dependent nurses can most effectively overcome their dependency? Please circle the number that indicates your level of agreement with each statement.

a. Alcohol and drug dependent nurses must ultimately overcome their dependency on their own. They should work hard to overcome their dependency. They should pick themselves up, admit that they are wrong and get themselves motivated to face their dependency head on.

STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE
1	2	3	4

b. Alcohol and drug dependent nurses must rely on the expertise of trained professionals to overcome their dependency. They should allow others to take charge and not risk taking chances on their own. They should not be blamed for their dependency nor be expected to overcome it by themselves.

STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE
1	2	3	4

c. Alcohol and drug dependent nurses must work with others to overcome their dependency. They should strive to overcome the obstacles imposed on them by their situation by using the help others give to the fullest. They should work to develop their own competence and potential and be serious in their efforts to overcome their dependency.

STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE
1	2	3	4

d. Alcohol and drug dependent nurses must accept the authority and discipline of others if they are to overcome their dependency. They should work to develop a sense of belonging with others who are experiencing the same kind of problems as theirs. They should admit that they have failed and devote themselves to something larger than themselves and their desires.

STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE
1	2	3	4

e. Which of the above statements best describes your view of how alcohol/ drug dependent nurses can most effectively overcome their dependency?

(enter letter a, b, c, or d) . . ____

25. Following are statements that have been made about drug and/or alcohol dependent nurses. Please indicate your level of agreement with each statement.

	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE
With help, drug/alcohol dependent nurses can recover fully	1	2	3	4
Drug/alcohol dependent nurses should be thought of as sick people	1	2	3	4
In general, drug/alcohol dependent nurses have not learned to assume the responsibilities of adulthood	1	2	3	4
Becoming drug/alcohol dependent is something that could happen to anybody . . .	1	2	3	4
Once treatment has been completed must drug/alcohol dependent nurses can resume their professional role as registered nurses	1	2	3	4

	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE
Once a nurse is drug/alcohol dependent the chances for full recovery are small . . .	1	2	3	4
CNEs have a responsibility to report drug/alcohol dependent nurses to the state licensing board	1	2	3	4
CNEs have a responsibility to refer drug/alcohol dependent nurses to sources of assistance	1	2	3	4
CNEs have a responsibility to terminate the employment of a nurse immediately once drug/alcohol dependency is confirmed	1	2	3	4
CNEs have a responsibility to report nurses who steal drugs to a law enforcement agency .	1	2	3	4
I would have difficulty trusting a nurse who has a history of drug/alcohol dependency	1	2	3	4
I would feel more comfortable hiring a nurse with a history of alcohol dependency than a nurse with a history of drug dependency	1	2	3	4
In general, I have more negative feelings about drug dependency among nurses than about alcohol dependency among nurses . . .	1	2	3	4

This last section deals with some background information about you and your hospital.

26. In what year where you born?

(enter two digits) . . . . . 19 ___ ___

27. Are you female or male?

Female 1

Male 2

28. In what year did you complete your first nursing degree?

(enter two digits) . . . . . 19 ___ ___

29. What is your current highest level of education?

Diploma 1

Associate Degree 2

Baccalaureate 3

Master's 4

Doctorate 5

30. In what year did you complete your highest nursing degree?

(enter two digits) . . . . . 19 ___ ___

31. How many years have you worked as a nurse manager/executive?

(enter number) . . . . . _____

32. How many years have your worked as a chief nurse executive?

(enter number) . . . . . _____

33. How long have you worked at your current hospital?

(enter number of years) . . . . . _____

(if less than one year, enter number of months) . . _____

34. How long have you worked as a CNE at your current hospital?

(enter number of years) . . . . . _____

(if less than one year, enter number of months) . . _____

35. What is your major clinical specialty area?

Medical/surgical 01

Psychiatric/mental health 02

Critical care 03

Maternal/child 04

Emergency 05

Pediatrics 06

Other (please specify) 08

_____

The last three questions refer to the hospital where you had most recent experience with a drug/alcohol dependent nurse. If you have had no experience within the past five years, please answer these questions about the hospital where you are currently employed?

36. What is the number of beds in the hospital?

(enter number) . . . . . _____

37. What is the number of registered nurses employed in the hospital?

(enter number) . . . . . _____

38. Is the hospital (circle all that apply)

Public? 1

Private? 2

A teaching institution? 3

Affiliated with a religious organization? . 4

What do you believe would be most helpful to you in dealing with nurses whose practice is impaired by alcohol/drug dependency? (e.g., educational programs, R & E staff to deal specifically with this issue, legislative changes, etc.)

Please use the back of the page if additional space needed for comments.

Please check to see that you have answered all questions that apply to you. Then fold the questionnaire, place it in the pre-addressed, stamped envelope, and drop it in the mail.

THANK YOU FOR YOUR HELP